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VOLUME 14

THE CHILD

JULY 1949

to JUNE–JULY 1950

EDERAL SECURITY AGENCY Social Security Administration • Children's Bureau

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CONNECTICUT SENDS HANDICAPPED CHILDREN TO CAMP

ELLEN E. OGREN

Medical Social Worker, Division of Crippled Children, Bureau of Maternal and Child Hygiene
Connecticut State Department of Health, Hartford

THOSE OF US who have attempted to send a handicapped child to camp know how disheartening it is to have the camp director say: "Our program is too active for a child who wears a brace," or "The terrain is much too hilly for a child with crutches."

Since the beginning of our State program, we medical social workers in the Division of Crippled Children of the Connecticut State Department of Health have tried to interpret to camp directors the children's special need for camp experience, but only a few children have been placed and only those with very slight physical handicaps.

We therefore welcomed an invitation, 3 years ago, from a Girl Scout director in the New Britain Girl Scout Council to assist her in setting up a special unit for handicapped children in her regular camp. This special unit had space for eight girls at a time for four 2-week periods. For 2 years the Division of Crippled Children assisted in selecting the girls. This unit has since become a permanent part of the camp.

To help the camp director and her staff in setting up a program for the handicapped children, members of the Division of Crippled Children (a nurse, a physical therapist, and a medical social worker) and members of the Connecticut Society for Crippled Children and Adults, Inc., spent some time at the camp, acquainting the staff with the children's needs. Together we chose a level section of the camp site easily accessible to the main dining cabin and the lake. The first year, the director appointed a counselor with pediatric nursing experience. Since a graduate nurse was part of the camp staff, however, during the second year the director appointed instead a counselor with experience in teaching and in directing recreational programs for handicapped children.

As nearly as possible the handicapped children's program was geared to that of the other campers. They had separate sleeping quarters but joined the regular campers for meals and shared with them the responsibility for daily camp chores and other camp activities. The director found that many of the children in the special unit could be and subsequently were transferred to the regular camp, where they adjusted very well. This experience showed that there is a place for handicapped children in regular camp programs, and as a result we decided to organize a committee to promote camping opportunities for the handicapped child.

State-wide planning

In the fall of 1947 we invited the agencies interested in physically handicapped children to attend an informal meeting for the purpose of discussing the camping needs of handicapped children throughout the State. Representatives came from agencies working with different types of handicapped children. We also invited representatives of Boy and Girl Scouts, recreational workers, social-service workers, and Junior Leaguers, as well as a representative of the Connecticut State Camping Association, the membership of which is composed largely of camp directors and other camp personnel.

The educational, recreational, and social experiences that go along with summer camping are even more important to handicapped children than to those who are physically normal.

We discuss the problem

As our first step in promoting camping opportunities for handicapped children, the participants in the meeting discussed the problem in order to formulate the need along clear-cut lines. We agreed that—

1. Education, recreation, and social experiences are important to every child but are perhaps even more important to the handicapped child. Camping offers an opportunity for the handicapped child to obtain these experiences through group living, through stimulation of special interests and skills, and through association with other children and adults outside the child's immediate family. It can contribute greatly to the handicapped child's development.

2. In order to provide camping opportunities for handicapped children, community understanding and planning are necessary.

3. Several different types of camps and camp programs are needed in order to give all handicapped children a camp experience.

a. A regular camp program should always be given first consideration because the child learns to live and play with physically normal children. He learns to understand and to accept the fact that he differs from his associates. This strengthens his confidence in himself. The handicapped children who should attend this type of camp would be those who are already attending school and who have learned to care for their personal needs. These children may have appliances which they have learned to use. In addition, they should have some emotional acceptance of their physical limitations.

b. For handicapped children requiring a more protective type of environment, a special unit in a regular camp may be necessary, but it should be set up in such a way as to give the child an opportunity to participate in the activities of the regular camp program. This unit can also be used for a child whose physical handicap is slight but who is not ready emotionally for group living in a regular camp.

c. The more severely handicapped children, such as those confined to wheel chairs or requiring nursing care or extended physical and occupational therapy, need a special camp. These camps would provide a modified camp program but would need specially trained personnel.

Loss of several fingers does not prevent this girl from taking her regular turn at the oars. This attitude is characteristic of handicapped children who have the advantage of camp experience.

d. Day camps are needed for handicapped children who may not as yet be ready for the experience of being away from home. The day camp would introduce the children to group experience and prepare them for going to a regular camp later.

We sell the idea to the camps

By having a representative of the Connecticut State Camping Association on our committee, we hoped to increase the association's interest in camping for handicapped children. The association was most cooperative in giving its support. It provided space in its publication to describe camping for handicapped children in a regular camp setting. The staff invited the committee to give a program at the association's semiannual meeting, and so we arranged for a panel discussion on camping for physically handicapped children, presented by a pediatrician, an educator, a rehabilitation worker, a medical social worker, and a handicapped child who wears a prosthetic appliance and has spent several summers in succession at a Girl Scout camp.

After the association's meeting, the committee received many inquiries from camp directors interested in accepting handicapped children in their camps. Many of the staff members of recreation divisions of local councils of social agencies were at the meeting. Later they discussed the subject in their own communities, with representation from the committee.

As a result of this local interest the committee received valuable information about some of the problems that camps were faced with in accepting handicapped children.

The committee received offers from a number of camp directors to take handicapped children in the summer of 1948, and we arranged to place 41 children in 10 camps. Twenty-three of the children went to regular camps and 18 to the Girl Scout camp with the special unit for handicapped children. We hoped that the experience of these camps would demonstrate to other camp directors that handicapped children can take part in a regular camp program.

The number of children sent to camp was limited by the available funds. The children's families contributed to the cost of care whenever possible, but even a 2-week stay was costly. The committee therefore appealed to charitable and civic groups for help, and some of the camps offered scholarships. The organizations and camps were very generous in sponsoring scholarships for these children.

The 41 children had varying kinds and degrees of physical handicaps. Some had orthopedic handicaps and used braces, crutches, or prosthetic appliances. The group included two children with cerebral palsy, two blind children, and some other children who used hearing aids. Several of the children had had rheumatic fever but it was now in the quiescent stage. Several had handicaps of a cosmetic nature, which either had been or were under surgical treatment. The children's ages ranged from 7 to 16, and the sexes were about equally divided.

We used considerable care in selecting the handicapped children for camp. We asked the child's own physician or the agency providing his medical care whether or not the child was able to participate in a regular camp program. We also obtained a summary of the child's physical and emotional problems, including recommendations for special care at camp. The counselors were told of any emotional factors which needed to be considered in helping the child to adjust to the camp program.

A Guide for the Placement of Handicapped Children, prepared by the Children's Welfare Federation of New York City, was helpful in outlining special camp programs that need to be thought of before placing a handicapped child in camp.

It was found that if the standards of medical and health supervision in a camp are good for the campers as a whole it is easier to adapt the regular camp program to the needs of the handicapped child. Before sending a child to camp, we visited the camp or sent a letter to the camp director to learn his attitude toward handicapped children and to find out how the camp program would be adjusted to meet the child's needs.

Nicky, for example, was placed in camp as a result of this answer from the camp director: "We would love the child and cooperate with him most unobtrusively; he would never know he was unlike anyone else." Nicky spent the entire summer in this private camp. He is a war orphan who came to this country with his mother. As a result of injury to his left arm during a bombing attack, amputation had been necessary, but it is still too soon for him to have an artificial arm. The warmth of the camp director's letter was a forecast of the pleasant experiences Nicky was to have at camp. He became very proficient in the use of his right hand and excelled in swimming and diving. Nicky was amazed that the other campers never mentioned his handicap, and his counselor reported that Nicky was accepted as one of the group.

Play with physically normal children often strengthens a handicapped child's self-confidence.

Two blind boys enjoy camp

Successful placement of two blind boys in a Boy Scout camp demonstrates that handicapped children can be adequately cared for in regular camps. These boys, both 14, attended a school for the blind during the school year. They were members of the Scout troop and so were familiar with scouting, but neither had had camping experience.

The following letter from their camp director clearly expressed his experience with these boys.

"The boys adjusted themselves to the camp program very readily. During the first 2 days of their stay at camp, other Scouts guided them about the area. Following this 2-day adjustment period, the boys were on their own, even to the point of checking in for regular and optional swim periods. They were treated as regular campers. No special favors were given. They took part in hikes, camp fires, pioneering events, and handicrafts. In fact, the only activities in which they did not participate were the competitive sports, such as baseball. We did not have to alter or adjust our regular routine, and the boys worked into it very nicely.

"Having the handicapped boys in camp was a benefit to our regular campers, and I know that our camp committee will include handicapped Scouts next summer."

One of the boys wrote the following letter to his social worker in the State Board of Education for the Blind, expressing his enthusiasm for the experience: "I am writing to let you know how I have enjoyed camp. I have never been to camp before or anything like it. I couldn't thank you enough to show you how much I enjoyed Boy Scout camp."

Parents commented about the benefits which they felt their children had received from camping. They found that the children had made great strides in self care and in independent thinking and planning.

A handicapped child goes to camp for the same reasons that the physically normal child does. He needs the same experience and satisfaction for his emotional development. We often find, however, that his handicap or illness has deprived him of the opportunities and experiences which the physically normal child usually has.

We also find that the child's camping experience may be used as an integral part of a case worker's plan for helping the child to adjust to his handicap. The following case report shows how Mary gained enough feeling of security from her camp experience to continue with group activities when she returned home.

"Mary, 14 years of age, has a bilateral harelip and cleft palate. With plastic surgery and orthodontic treatment her appearance has greatly improved. As a result of several years of speech training her speech is good.

"Yet she is extremely conscious of her appearance, as the scarring of her lip is evident and there is a nasal quality to her speech.

"She was brought up in a home where, as an infant, she was adopted by an aged couple who were childless. Because they had no relatives, they were anxious for her to receive their small estate. It is a home where the adoptive parents have given her a great deal of warmth and security, but there has been considerable overindulgence on the part of these parents, who have wanted her to remain a small child. Mary has been struggling against this.

"She had a period of treatment at a child-guidance clinic but continued to resist group activities and withdrew to reading books and listening to the radio. The medical social worker of the Division of Crippled Children spent considerable time in preparing Mary for camp experience.

"Finally, Mary spent a month at a small private girls' camp. Her first letter to the worker indicated a good deal of insecurity and homesickness. However, her statement that it was such fun to be with counselors who treated her as an adult caused the counselor to assign Mary to a cabin with slightly older girls. Here she was accepted as one of them and given the same responsibilities as others in the group. This seemed to give her considerable encouragement, since she was receiving treatment as a young adult for the first time.

"In the fall following the camping experience, she expressed a desire to join the local Girl Scout troop. She is now taking an active part as a leader of one of the Brownie units. This camp experience has definitely contributed towards Mary's growth and adjustment to her handicap. She is less introspective and has more acceptance of her difficult home situation."

Narrative reports of this kind, sent in by the counselors and directors, furnish valuable information about the children to the agency staff and to the parents, who will be working with the children for the rest of the year.

An interesting report was received from a camp where two girls with similar handicaps were sent at the same time. Although the handicaps were similar, the girls had very little else in common, and it might have been better if they had been sent to separate camps. Together they seemed to find it easier to withdraw and shun the companionship of the other campers. The director, however, finally solved this problem by assigning the girls to different groups within the camp.

The committee did not develop special report forms but depended on the camp directors to send the referring agencies a summary of the child's reaction to his camp experience, including the manner in which he fitted into the camp program, his relationship with other campers and with counselors, and any evidence of an attitude on the child's part of invalidism or of defensiveness.

Other agencies send children to camps

In addition to placing these children in camps, the committee answered inquiries about camping resources from many agencies in Connecticut which were interested in placing handicapped children. Through these inquiries it was realized that other agencies were also placing handicapped children in regular camp programs.

Summer placement of handicapped children in regular camps had been the chief concern of the committee. The State camping association accepted this project as its responsibility and at its December 1948 meeting voted to invite the committee to become one of the association's permanent committees. This will give us affiliation with an agency, and it is anticipated that through this relationship the interests of the committee will be furthered. The committee has afforded all its members an opportunity to learn more about the work of other agencies concerned with handicapped children and has broadened their interest and knowledge of camping.

The present committee has representation from the following agencies: Connecticut Society for Crippled Children and Adults, Inc.; Newington Home and Hospital for Crippled Children; Boy Scouts; Girl Scouts; Recreational Division of the Hartford Council of Social Agencies; Division of Special Education of the State Department of Education; State Board of Education for the Blind; Social Service Department of the State training schools (in reference to children with epilepsy); schools for the deaf; Hartford Junior League; Connecticut State Camping Association; and Division of Crippled Children of the Connecticut State Department of Health. This committee works together because of mutual interests and concern to provide group experiences for the handicapped child.

Future plans of the committee

The committee is planning to sponsor a pictorial leaflet highlighting some of the experiences to be gained by sending handicapped children to regular camps. This folder will be sent to civic groups in order to increase their understanding of the handicapped child and to stimulate their interest in providing scholarship funds for camping. It will also be sent to camp directors to interest them in providing more opportunities for handicapped children.

We are exploring the possibility of using day camps to prepare many other physically handicapped children for camping experience without separating them from their parents until they are ready.

We are also interested in development of a camp where the more severely handicapped children may enjoy the experience of group living but also continue their treatment.

And of course the committee will also continue its efforts to make camping available to every handicapped child who would like to have this experience.

Reprints in about 4 weeks

AMERICA WELCOMES DISPLACED ORPHAN CHILDREN

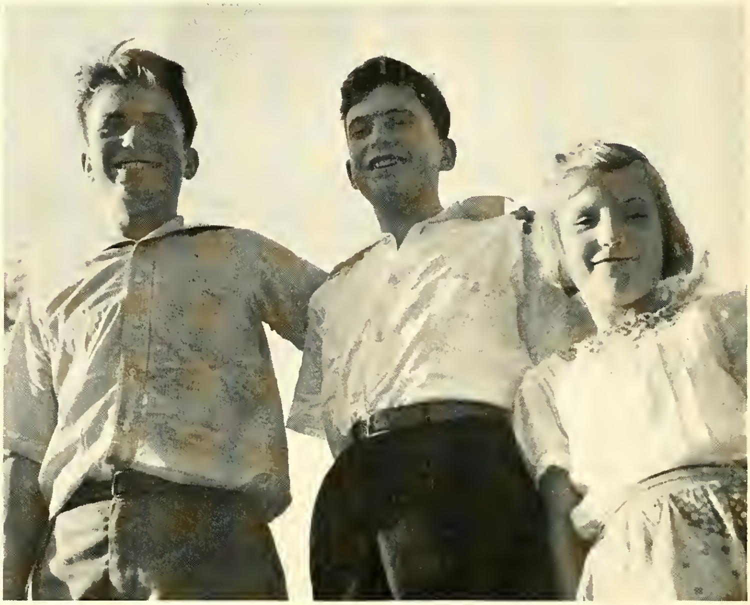
I. EVELYN SMITH, *Consultant on Foster Care, Social Service Division, Children's Bureau*

EVEN BEFORE Hitler's armies drove into Poland, starting World War II, some orphan children, fleeing religious and racial persecution, were coming into the United States, with the help of foreign-relief organizations, to start a new life as Americans.

The next group of children to come in without any families were not orphans; and they were not coming to the United States to stay. They were children that British parents sent out of England to escape bombing. It was to coordinate the many services needed by these children that the U. S. Committee for the Care of European Children, Inc., came into being in 1940. This group, a voluntary, nonprofit organization established in conjunction with the major Protestant, Catholic, and Jewish child-care agencies of the United States, has ever since been coordinating the available resources for the care of child war victims coming to the United States without parents or other relatives.

The British children, all under 16, were admitted under emergency immigration procedures adopted by the Departments of Justice and State; and as part of an agreement between the U. S. Committee and those Departments, the children were under continuous supervision of welfare organizations and were cared for according to standards set by the Children's Bureau.

The end of hostilities found thousands of European children homeless and without parents. Large numbers of these children, along with adults, were gathered into displaced persons' centers and were cared for there by international organizations. The United Nations Relief and Rehabilitation Administration was working to solve the problems of the displaced persons, as well as several individual governments, including Switzerland, Sweden, France, and Great Britain. But large numbers of both adults and children had no place to stay safely except in the centers.



America is the land of hope to children who have lost father and mother, home, and country.

A few months after VJ-day, President Truman issued a directive planned to enable many displaced persons to come into the United States quickly. "In this way," he said, "we may do something to relieve human misery and set an example to the other countries of the world which are able to receive some of these war sufferers. I feel that it is essential that we do this ourselves to show our good faith in requesting other nations to open their doors for this purpose."

The directive (December 22, 1945) instructed the responsible Government officials to establish, "with the utmost dispatch," consular facilities at or near the places where displaced persons were staying, and to take other steps to speed up their entry into the United States.

In the directive the President said, "I desire that special attention be devoted to orphaned children, to whom, it is hoped, the majority of visas will be issued."

During the 2½ years that this directive was in force, approximately 42,000 displaced persons were admitted to this country under the regular quotas set by the immigration laws for the different countries. This number included more than 1,000 under 21 years of age, who were "unaccompanied"; that is, whose parents had died or could not be located. All these were brought in under the simplified immigration procedure that was started as early as 1940 for the British guest children; they were cared for under the supervision of welfare agencies, according to Children's Bu-

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Based on paper given at the Second Pan-American Congress of Social Work, held July 2-9, 1949, at Rio de Janeiro, Brazil.

reau standards, just as the guest children had been.

The Displaced Persons Act of 1948 (approved by the President June 25, 1948) specifically terminated the President's directive. The act authorizes admission into the United States of 205,000 displaced persons during the 2 years ending June 30, 1950, "mortgaging" 50 percent of the quotas of succeeding years. The number authorized for admission includes 3,000 orphans under 16 years of age. (At the time the act was passed there were 2,700 unattached children under 16 years of age in the allied occupation zones.)

Responsibility for carrying out the purposes of the act is in the hands of a Displaced Persons Commission created by the act. This commission has three members, appointed by the President.

To be eligible for admission to the United States under the Displaced Persons Act of 1948 a displaced orphan under 16 years of age is required to have been in Italy or in one of the western areas of Germany, or in Austria, on or before the date on which the act became effective, June 25, 1948. Also, as the act is interpreted by the Department of State, the orphan must be under 16 years of age when the American Consulate in the country where he is living issues an immigration visa for him.

In addition to the requirements that these children be under 16, that they be orphans, and that they shall have been in specific geographical areas at a certain time, certain other conditions are set by the act, such as that the children be qualified under United States immigration laws, and particularly that assurance be given that they will be cared for properly if admitted to this country.

The Displaced Persons Commission may require information showing that the reception, placement, and care of the children will be in conformity with the standards of the Children's Bureau.

Assurances that the children will be cared for properly may be given by organizations authorized by the commission for this purpose and also by individuals seeking to have specified children, who are related to them, enter the United States.

In connection with such care, the commission must be assured that the child will attend regular sessions at a school in the United States.

The immigration laws exclude anyone likely to become a public charge. And under the Displaced Persons Act of 1948, the U. S. Committee, as sponsor, guarantees that the orphans will not become public charges.

The commission's regulations define a public charge as a person requiring "aid at public expense for essential food, clothing, or shelter, or for medical treatment for causes existing prior to entry into the United States under the act." However, a person is not considered to have become a public charge by reason of receiving public *services* (other than financial assistance) available to persons in the community in which he resides.

The U. S. Committee retains continuing responsibility for orphans whose admission it sponsors until the child becomes 18 years of age or until the committee's responsibility is terminated by circumstances related to the legal status of the child, such as adoption or marriage.

Their early sufferings now in the past, these little girls are looking toward a new life.

How agencies cooperate in plans for displaced children

The job of selecting children overseas who are qualified under the immigration laws to enter the United States, and resettling them in this country, involves special problems not met with in helping adult displaced persons. To deal with these special problems of children the Displaced Persons Commission has authorized the U. S. Committee for the Care of European Children to bring in a specified number of children whom the U. S. Committee itself is sponsoring.

The Displaced Persons Commission also has authorized the U. S. Committee to accept and process applications from individuals who desire to sponsor certain displaced orphans who are known to them. The committee has a staff overseas, screening applications from children wishing to come to this country and obtaining the necessary information.

The committee does not itself find homes for children. It allocates them, for placement, to units of voluntary foreign-relief organizations — Protestant children to the National Lutheran Council (of Church World Service, Inc.) or directly to local nonsectarian agencies: Jewish children to the European Jewish Children's Aid (of United Services for New Americans, Inc.): and Catholic children to the Catholic Committee for Refugees (of the National Catholic Welfare Conference).

These units arrange for placement of children through local agencies.

These newcomers are staying in a reception center before being taken to their new homes.

As with the previous programs for displaced children, the Children's Bureau has been given responsibility, this time by the Displaced Persons Commission, for setting standards for the reception, placement, and care of the children.

The Bureau has prepared a statement of such standards: these cover care of children in foster homes under the supervision of child-caring agencies, those in temporary reception centers, and those in other types of group-living arrangements. The Bureau has based these standards on policies and practices that are being followed by qualified agencies in providing care for American children.

State and local agencies help

At the request of the U. S. Committee, the Children's Bureau designates individual local child-caring agencies as approved for giving care to these children.

Before designating an agency to give cooperative service in caring for displaced children the Bureau asks the child-welfare division of the State department of welfare about the quality of care given children by the agency and asks the agency itself for information on its program. The State departments of welfare have helped greatly in assuring care for these children in accordance with standards that experience has shown to be desirable.

One hundred and sixty-four agencies in 38 States have been so approved by the Children's Bureau.

Ship or airplane transportation from Europe to ports of entry in the United States is provided by the International Refugee Organization without cost to the displaced person or his sponsor. The sponsor of a displaced person, however, is responsible for his reception and inland transportation from the port of entry. Since the U. S. Committee is the sponsor of the unaccompanied orphans, representatives of the committee meet the ships and planes on which the children arrive; and they arrange transportation to the committee's reception center in New York.

Unaccompanied children entering the United States usually need reception care for a while—long enough for the committee to make plans for their placement in family homes or in group care and to determine their general physical condition and special needs which may affect such plans. How long a child stays in a center depends on the time needed to work out an individual plan for him. On the average children stay in the center about 20 days. Then they are taken to private welfare agencies in different parts of the country.

A longer period of temporary care, frequently in the community to which the child is assigned, may be necessary before he is placed in a family home.

Although all children selected overseas must meet United States immigration requirements as to physical condition before they are granted a visa, a complete medical examination is given again when the child is in the reception center. During the reception period the children receive new outfits of clothing. Some instruction in English and orientation to the customs of this country are part of the reception program.

Number, countries of birth, ages

The total number of unaccompanied children that have entered the United States under the auspices of the U. S. Committee for the Care of European Children, from 1940, when the committee was organized, to June 30, 1949, is 3,080.

The number of unaccompanied children under care of local children's agencies, the U. S. Committee, and the three national agencies previously mentioned was 1,815 on June 30, 1949.

Of this number, 206 were admitted before the President's directive went into effect; 1,236 were admitted under the President's directive; 366 have been admitted under the Displaced Persons Act; and 7 were stowaway children.

The countries of birth from which the largest numbers of children have come are Poland, Czechoslovakia, Hungary, Germany, Roumania, Lithuania, Estonia. Smaller numbers have come from Austria, Bulgaria, Danzig, France, Italy, Latvia, Russia, Turkey, and Yugoslavia.

Many requests have come from people wishing to care for very young war orphans. However, the majority of the children coming in under the auspices of the committee have been in the age group 14–18 years. Consequently it is not possible to meet the requests of families wanting to adopt young children.

One reason why the number of children admitted is not greater is that most of the European countries have regula-

(*Continued on page 12*)

A CITIZENSHIP PROGRAM COMES OF AGE

LUCILE ELLISON, *Assistant Secretary*

National Commission for the Defense of Democracy Through Education, National Education Association

THREE HUNDRED STRONG, the luncheon group grew still. Ten boys—their faces intelligent and sensitive but strongly different with the racial strains of six nationalities—looked across the audience. Now youthful voices rose clear and flutelike: "I am an American."

It was mid-May in New York, and the Fourth National Conference on Citizenship was in full swing.

Ready to begin, a panel of nine people sat at the head table. Three men would tell how citizen groups in three varied communities saw what they knew to be wrongs, how they banded together, studied their problems, tackled the opposition, and won. Representatives of industry, church, labor, schools, veterans, youth, would question and learn of their place in such concerted action.

The conference reporter arose to speak for sixteen discussion groups: "This is the second report from you to you, highlighting the accounts of our thinking together. . . .

"One group tells us that Americans should realize. . . . Fear is one of our troubles. Fear leads us to do foolish things. . . . Sometimes we are afraid of people. Keeping people out—out of our organizations, out of our neighborhoods, out of our country—is not going to solve the problem. The American tradition is to welcome the friendless and oppressed. . . ."

How did such a conference, a National Conference on Citizenship, come about? What is its purpose? What can it hope to accomplish?

In 1945, the newly formed Citizenship Committee of the National Education Association resolved to gather what was being printed in the field of citizenship. Accordingly, letters went out to all organizations discovered to have the word "citizenship" in their titles or listed among their committees.

Findings were sparse. In its search, the committee noted considerable duplication in the little that was being done. Something was needed, committee members felt, to dramatize the need and to bring together efforts pointed toward the goal of effective citizenship. They set up three objectives for a proposed gathering of those organizations and agencies concerned:

1. To reexamine the functions and duties of American citizenship in today's world.

2. To assist in the development of more dynamic procedures for making citizenship more effective.

3. To indicate the ways and means by which various organizations may contribute concretely to the development of a more active, alert, enlightened, conscientious, and progressive citizenry in our country.

To accomplish these objectives, the committee members were convinced they would need to cut across as many groups as possible, as many facets of American life as possible. Certainly youth, and those organizations and agencies that work with youth, would be included.

On May 17, 1946, with Chief Justice Harlan F. Stone as honorary chairman and with the blessing of the President of the United States, the First National Conference on Citizenship was convened in Philadelphia. Eighty-three national figures—representatives of labor, industry, government, education—served as honorary sponsors.

This first conference, a small one of 140 delegates, the committee on appraisal termed "a milestone in democratic relations," where "people from such varied groups sat down like a family, with mutual respect for each other, to talk together in serious, frank, and free manner, about how the responsibilities of citizenship might best be discharged."

At the close, the delegates expressed, in resolution, "the hope that it will be possible for the National Education Association to continue this important service and to arrange another such conference next year."

As a further test of the usefulness of the meeting, a questionnaire went out asking such questions as: "Would you like to have another conference?" "Would you be interested in coming

Keeping well informed on world happenings is an important step toward effective citizenship.

again?" "How can we improve the conference?" In reporting on this questionnaire, the Conference Chairman said: "Two amazing things happened. In the first place, we got most of the questionnaires back. . . . Over 90 percent of them wanted another conference."

As a consequence, in 1947—again with significant patronage and sponsorship—the Second National Conference on Citizenship was held, this time in Boston.

In 1948, a much larger and more far-reaching conference brought in nearly 1,000 delegates, representing 400 national organizations and agencies. The United States Department of Justice, which had cooperated and advised on the earlier two conferences, became a joint sponsor. In 1949, under this joint sponsorship, the series was continued in New York.

More young people participate

Early realized in the planning, and reemphasized again and again, was the fact that, if citizenship were to be considered in any comprehensive manner, youth must be represented. Thus, from the beginning, the committee sought the help and participation of youth. Youth participation has increased with each conference.

In the fourth conference, two students appeared on general session programs; four served as discussion leaders; and high school and college students, though still in insufficient numbers, were scattered throughout the 16 discussion groups. A member of the conference committee met with them twice, once to help to orientate them to the conference idea, and again, at their request, to help them to pool their thinking.

In both 1948 and 1949, the conference used the general session to present a topic, followed by small groups discussing simultaneously the topic as presented.

Our jobs as responsible citizens

Theme and discussion topics for 1949 were: "RESPONSIBLE American Citizens—1. Their Job in Politics. 2. Their Job in the World Today. 3. Their Job in the Community."

Notable speakers took part in general session programs, among them Senator George David Aiken of Vermont, Senator Hubert H. Humphrey of Minnesota, President Anna Lord Strauss of the League of Women Voters of the U. S. A., Attorney General Tom C. Clark, Chancellor Robert Burton House of the University of North Carolina, President Mabel Studebaker of the National Education Association, and President Justin Miller of the National Association of Broadcasters.

Dividing the conference into small groups broke through many of the barriers to expression and allowed every delegate to voice an opinion. Youth delegates were accepted into full membership and partnership. Thus it could happen that a high-school youth from New England had his say while a gray-haired laborer from the Midwest listened intently. And both could feel that they had a voice in the thinking emanating from the conference.

Too, the device of using a "thumbnail reporter," to gather the thinking of the groups and report back to general sessions, gave opportunity for collection of the best expression of all conference participants. Delegates were enthusiastic over this arrangement.

From the reports came many gems of advice and helpful comment. Typical are the following excerpts:

"Nobody is anybody at all, all by himself. A voter may show up as Sam Smith, but Sam is somebody because of other people and his relationship to them. If we are smart, we will treat him that way."

"The family is not the only social unit, of course, but it is an important one. As we think about better communities, let us think about better families and how to help families to make better communities.

"Age groups, too, are important—the young, the middle-aged, and the elderly. The middle-aged tend to monopolize things. When they do get around to thinking of other age groups, they tend to think first of the young, for they are our future. But let us not forget our growing group of elderly people who may have experience and leisure to give significant community service.

"We who are middle-aged have no monopoly on energy or wisdom. Let us elicit the help of kids and older people. We might be surprised at the help they can give.

"While we are on the subject of age groups, one of our discussion groups points out that the children and youth of a community can often be the focus for community action.

"If your community suffers from apathy, maybe it can be made into a working team by focusing attention on the needs of children. There are many possible points of focus, but if you are looking for one that has dramatic and universal appeal, there is nothing to surpass children. Kids are wonderful catalysts.

"Many people do not seem to fall into the easy categories of our society—as families, as age or ethnic groups. They feel left out for some reason or other. If we are to build strong communities, we must put out the welcome mat for everybody (and that means *everybody*)!

"These, then, are the recommendations made to us:

"1. Know your community.

"2. Get into the swim of things.

"3. Use your vote wisely and urge others to do so.

"4. Think of people in groups, not merely as toy soldiers. Think of them as members of families, age groups, clubs, and other types of groups. Give a welcome to everybody."

For the fifth conference

At the close of the 1949 conference, an evaluation group made two suggestions, looking toward implementation of the conferences throughout the country:

"1. In order to promote citizenship conferences systematically on a State level, after the fifth conference has been in session a day or two, delegates should meet by States to discuss possibilities.

"2. In order to stimulate action through the conference, next year the last conference period might be devoted to 'How do we communicate the impact of this conference back to the group represented?' The final session might spell out in detail the steps of such communication."

The evaluation group commended many features of the fourth conference and recommended that a fifth conference be held May 18–21, 1950, with the specification: "The conference was so fine there should not be too many changes another year."

Reprints in about 4 weeks

URUGUAY WORKS FOR ITS CHILDREN THROUGH THE COUNCIL OF THE CHILD

ANNA KALET SMITH, *International Cooperation Service, Children's Bureau*

AN EXAMPLE of unification of health and welfare work for children of all ages in one Government agency—infrequent in the American Republics—is found in Uruguay, a country with a population of about 2½ million, mostly rural. The agency is the Council of the Child (Consejo del Niño), with headquarters in Montevideo. It was created in 1934 in compliance with a law of that year, called the Children's Code.

The code, which is sometimes called the Charter of the Rights of the Uruguayan Child, is a law of wide scope and progressive principles. It covers nearly all matters relating to children and specifies the functions of the Council of the Child.

The council, which consists of a full-time director and eight other officials, implements the code. In this work it is aided by a technical salaried staff and local volunteer committees of cooperation.

Health and welfare integrated

Welfare work for the children is combined with health services, because—in the words of the council's latest report—the health of children is closely connected with economic and social conditions. Particular attention is paid by the council to children under 3 years of age.

The council's work begins with the prenatal period, and its Division of Prenatal Care (División Prenatal) functions chiefly through maternity clinics. This division also maintains a shelter for unmarried mothers and their babies, and free lunchrooms for expectant and nursing mothers, and it subsidizes private agencies aiding unmarried mothers. Expansion of this division is planned.

To keep mother and child together

The council's Division of Infancy (División Primera Infancia) is guided in its work by the principle of avoiding separation of mother and child. If a mother is unmarried or for some other reason finds difficulty in supporting her child the council helps her financially or in other ways to enable her to keep the child with her. The child is then supervised by a "visitor." Some, but not all, of the visitors are graduate social workers. When separation is unavoidable, the child is sent either to the home of a wet nurse or to a foster-family home, the council paying for the child's care.

In Montevideo the Division of Infancy maintains day-care centers, stations for distribution of milk and milk mixtures for children, and clinics at which well children under 3 years of age are examined and vaccinated; treatment is given there in emergency cases only. Attendance at these clinics is required for children under 3 years of age: (1) Who belong to low-income families living in the territory served by a clinic; or (2) who have been placed in foster-family homes by their parents; or (3) whose mothers receive any form of aid from the Division of Infancy. Prematurely born children also must be brought regularly to the clinics.

In 1947 the division had 17 such clinics in Montevideo, with a total registration of 15,000 children under 3, or more than one-third of the children in this age group in the city; the attendance, however, was much lower. The number of children registered each year is about 6,000, which represents more than one-third of the annual births in Montevideo.

Until recently the council has been confining its work for children under 3 almost entirely to Montevideo, but since the appropriations were increased, in 1944, the council has created several maternity and child-health clinics in the rural areas. Their number, however, like that of the city clinics, is insufficient.

Children between the ages of 3 and 14, who have no parents, or whose parents are unable or unwilling to care for them, are referred to the council's Division of Older Children (División Segunda Infancia) by public or private agencies or individuals.

After a short stay at the receiving center, the council places most of these children in cottage-type institutions or in carefully selected foster-family homes. The council is a recognized pioneer in these two forms of placement in Latin America, and the number of children under such care is said to be proportionately larger in Uruguay than in any of the other Latin-American countries.

Children in foster-family homes supervised

Visitors supervise the care given the children in foster-family homes and make sure that they attend school regularly. About 4,000 children receive such care in Montevideo, their board paid in most cases by the council.

The Division of Older Children supervises children in foster-family homes, even if they have been placed by their own families.

Special institutions are maintained by this division of the council for children under 14 years of age who have behavior difficulties and for those who have been brought before a juvenile court. In all the institutions the children receive individual study, also an elementary education and medical care.

This division also maintains in Montevideo several day-care centers for preschool children and several free clinics at which children between the ages of 3 and 14 receive medical and dental examinations and educational and mental tests. A psychiatrist has been employed since 1942. Visitors call at the homes of the children attending the clinics.

In recent years the division has been caring for about 6,000 children at a time. It receives on the average 1,500 cases annually.

The Division of Hygiene (División de Higiene) supervises the health of elementary-school children. In Montevideo half of these children receive annual medical examinations. Some form of dental care is given to 15 percent of the elementary-school children in the entire country. Immunization work is done, and in recent years some children have received X-rays of the chest and tuberculin tests. Cases in need of treatment are referred to public-health clinics.

Clinics beginning work

A behavior clinic has been set up in Montevideo. And a traveling school-health clinic, staffed by a physician and a nurse, has been put into operation in rural areas.

The division also directs the work of open-air schools, vacation camps, seashore colonies, and preventoriums for children exposed to tuberculosis.

The council's Division of Adolescence and Employment (División de Adolescencia y Trabajo) has two main functions: First, it cares for dependent or wayward children between 14 and 21 who are referred to it by a juvenile court or other agency, or by the parents. Secondly, it administers the child-labor provisions of the Children's Code.

Dependent or wayward children referred to the council are first placed in a clearing center for a preliminary physical examination, a mental test, and an investigation of their background. A child may be returned to his parents, or he may be placed in an institution for normal youth or in one for cases with special problems.

Several institutions are maintained by the council. They are situated in rural areas and have facilities for teaching the boys and girls farming and suitable trades. This, together with regular observation of their physical and mental health, instruction in elementary-school subjects, and training in habits of work, helps the boys and girls to return to society able to support themselves. Some of these institutions have been reorganized on the cottage plan, with a married couple acting as house parents. The children are not locked in; they have freedom of movement.

To facilitate the adolescent's readaptation to outside life after he is discharged from an institution, the council has established a special after-care institution. Also some boys and girls are placed in foster-family homes, under supervision of the previously mentioned behavior clinic.

To protect young workers

As part of this division's administration of the child-labor clauses of the code, it issues the work permits that are required for boys and girls 14 to 18 who enter employment or change jobs. A permit is issued if the child passes a physical examination, if the job is suited to his physical ability, and if he has the required schooling. Children between 12 and 14 receive permits in cases of proved hardship.

The Legal Division (División Jurídica), which according to the law must be directed by the judge of the juvenile court of Montevideo, exercises guardianship over the children placed by the juvenile court under the care of the council; also it administers the laws on adoption and on the payment of support by fathers of children born out of wedlock. It takes legal action for recognition of paternity, and it helps to bring about marriage between the parents. The work of this division is important because of the high rate of illegitimacy in Uruguay.

The council obtains most of its funds from the Government treasury but it also accepts private gifts.

Sources: República Oriental del Uruguay, Consejo del Niño, Memoria del Consejo del Niño 1943–1946, Primera Parte, Montevideo, 1947; the same report, second part, in galley proof; and Boletín del Instituto Internacional Americano de Protección a la Infancia, Montevideo, 1942–49.

Displaced Orphan Children

(Continued from page 8)

tions that prevent children's being taken out of the country for purposes of adoption or resettlement. Because the populations of European countries have been greatly reduced as a result of the war, the governments are anxious to keep all children who are their citizens; and they usually wish to repatriate such children who have been found in other countries.

Family homes desirable for most displaced orphans

Displaced children coming to the United States need individual consideration of their problems. They need to feel that they belong, and that they share interests with other people, both adults and children. The variations in background, temperament, and special needs of these children suggest that for most of them, individual care in a family home is best. This plan offers greater possibility for the child to participate in normal family life and community activities than does group care. For this reason the Children's Bureau, in its standards, has placed special emphasis on the desirability of home care for the displaced children.

The Bureau recognizes, however, that for certain children, especially the older adolescents, placement in group care may be more acceptable than placement in individual family homes. Therefore a few children have been placed in residence clubs or boarding schools and a few in institutional group care.

Agencies giving case-work services to displaced children have found that some of them have certain marked emotional problems, especially the adolescents. This is the natural result of the severe deprivations suffered by the children, the complete lack of any normal childhood, and their grief at the loss of mother, father, home, and country.

In planning for these children's care all of the organizations concerned are making a sincere effort to give the services that the children need. The job of helping these children to make a satisfactory adjustment to the loss of everything they held dear and to face the future fearlessly is a real challenge to all of us.

Reprints in about 4 weeks

IN THE NEWS

State Dental Directors Meet With Federal Agencies

State dental directors held their second annual conference with the Public Health Service and the Children's Bureau, both of the Federal Security Agency, at Washington, June 8–10. Forty States, the District of Columbia, the Virgin Islands, and Puerto Rico were represented. The conferees discussed ways to extend public dental-health services, including wider use of the topical application of fluorides to reduce decay in children's teeth.

American Academy of Political and Social Science Considers Delinquency

This is the fiftieth year since the inception of the juvenile-court movement. It is also a time when people in the welfare field, and the general public as well, are showing a high degree of concern regarding delinquency. This subject has become so popular that throughout the country varying legislation has been introduced, special projects and programs have been put into operation, and remedies of all kinds have been suggested by both lay and professional groups.

This comparatively sudden activity has been unfortunate in some respects. There has been a tendency to oversimplify the problem, when in reality it is one of the most complex we have to face. There also has been a tendency to place this problem in a category by itself, when in fact it can not be disassociated from any broad child-welfare program.

It has been therefore both timely and appropriate for a recent issue of the Annals of the American Academy of Political and Social Science to focus its attention on juvenile delinquency. The issue is devoted to a series of 17 articles by recognized leaders in their fields, all of which are, or should be, component parts of a total program for the prevention and treatment of delinquency. Many readers would have welcomed the addition of articles on education and child health in relation to this problem.

These articles should contribute a great deal toward clarifying the function of the juvenile court for a community welfare program. They present the philosophy of the court, its strengths, and its limitations, as well as its past development, present status, and possible future developments.

Causative factors in delinquency, certain aspects of treatment, and preventive programs are also presented. In reading these articles one gains a perspective of the many social and legal complexities involved.

The articles discuss many situations involving the functions of the juvenile court, its responsibilities, its organization, and its needs, which have led to misunderstanding and points of conflict in the past. Whether or not one agrees with the conclusions the authors arrive at, the viewpoints expressed are stimulating and challenging and merit careful consideration by all interested in the welfare of children.

William Sheridan

UNICEF Aids Philippine Children and Mothers

Approximately 1,000 students in public elementary schools in Manila will be served supplementary mid-day snacks of milk and fish-liver oil as part of the $300,000 program approved for the Philippine Republic by the United Nations International Children's Emergency Fund (UNICEF).

Initial plans are aimed at feeding 1,000 pupils for 5½ months, but it is expected that resources will soon permit a considerable expansion of the project.

In addition, the Philippine program calls for one daily supplementary meal for 7,650 preschool children and 1,700 expectant and nursing mothers, who will be served in 85 child-care centers for 10 months.

Child Workers Killed While Illegally Employed

Within 12 months, in the same Alabama county, two young boys were killed while employed in hazardous occupations in violation of the child-labor provisions of the Fair Labor Standards Act of 1938.

In the latest accident, which occurred last summer, a 13-year-old boy died 4 hours after he was struck on the head by a limb of a falling tree while at work in the woods near Chatom, Washington County, Ala. This boy and five other minors had been illegally employed in logging operations.

Six months earlier a 14-year-old boy had been on the job in a nearby Washington County sawmill only a week when he was hit by a piece of timber that went through his body. He died the next morning.

The Fair Labor Standards Act sets 18 as the minimum age for employment of minors in most logging and sawmill operations, including any job at the place where trees are being felled.

In each of these cases, the United States District Court at Mobile has permanently enjoined the employers from any further violations of this nature.

Reports of the Department of Labor show that many children have been injured, permanently crippled, or killed while illegally employed in hazardous occupations around sawmills and logging operations, and it is the firm purpose of the Wage and Hour and Public Contracts Divisions to clean up this situation as rapidly as enforcement facilities permit.

Immediate help can be had by employers who want to escape unintentional violation of the law from a publication entitled A Guide to the Child Labor Provisions of the Fair Labor Standards Act. This may be obtained without cost from the Wage and Hour and Public Contracts Divisions, United States Department of Labor.

Special Ambulance Carries Premature Babies

New York City has a special ambulance for transporting prematurely born babies from the hospital where the birth took place to a hospital that has adequate facilities for care of prematures. The ambulance carries a supply of oxygen and an incubator and is attended by a specially trained nurse, one of a staff of five assigned for this work. Around-the-clock service is provided, and no charge is made. The project is under the joint auspices of two city departments, the department of health and the department of hospitals.

Marriage Reform Bills Passed by Indian Parliament

The Indian Parliament has raised the marriageable age of girls from 14 to 15 years (marriageable age of boys remaining at 18) and has raised the age of consent from 14 to 16 in respect of extramarital offences.

SOURCE: *Government of India Information Services, April 7, 1949.*

Program for Hard-of-Hearing Children Established

A hard-of-hearing program has recently been inaugurated in Birmingham, Ala., at the Jefferson-Hillman Hospital. The program at this time calls for correction of hearing defects of school children in Birmingham—defects that were revealed in a survey completed earlier this year.

It is hoped that the program will later be expanded to include preschool children, as well as school children throughout the State between the ages of 5 and 18.

The State health department has provided $4,000 to help equip the Jefferson-Hillman Hospital for this program, and the Rotary Club of Birmingham has raised some $30,000 to pay for hospital care.

For Children With Cerebral Palsy

An organization has been formed in Birmingham, Ala., entitled Spastic Aid, Inc., for the purpose of raising funds for the benefit of children with cerebral palsy. Its original plan of subsidizing a private custodial institution has been abandoned. Instead, the funds will be turned over to the State Crippled Children's Services for supplementation of its special project for cerebral-palsied children.

Program for Hard of Hearing Benefits Children in Black Hills

In the sparsely settled region of the Black Hills more than 9,000 children have been given audiometric tests in a special program for the hard of hearing under the auspices of the maternal and child-health program of the South Dakota State health department. Children found to need corrections or assistance in combating hearing and speech difficulties are rapidly being taken care of.

A typical example of a parent's interest in getting help for his child is the action of a father who, in order to take his 7-year-old son to the office of the audiometric technician and speech correctionist, left his house with the boy at 4:30 a. m., drove 25 miles to the bus station, and traveled nearly 80 miles after that to reach the clinic.

FOR YOUR BOOKSHELF

YOUR CHILD OR MINE; the story of the cerebral-palsied child, by Mary Louise Hart Burton, in collaboration with Sage Holter Jennings. Coward McCann, Inc. New York, 1949. 64 pp. $1.25.

This little book is surely an intelligent and successful method of presenting a difficult subject in a simple way. The life stories of six children are described, each with a different type of cerebral palsy, and from these stories a person knowing little or nothing of this condition can achieve an understanding of what cerebral palsy is, how it may come about, what attitudes parents have toward a child so affected, and how the other siblings in the family may react to the brother or sister who has cerebral palsy.

This is clearly intended to be a "hopeful" book, as only one of the six children is mentally retarded and the others all improve considerably. There is a good summary, which points out that the services needed are only exceptionally available.

No reference is made to the work of State crippled children's agencies or of State and local departments of education, work that is becoming considerable. The problems of family adjustment to this situation are well illustrated, but the help that is forthcoming in many communities through medical-social and psychiatric consultation is not mentioned. The inclusion of such discussion in a future edition would be desirable.

Arthur J. Lesser, M. D.

EMIC (Emergency Maternity and Infant Care); a study of administrative experience, by Nathan Sinai, D. P. H., and Odin W. Anderson, Ph. D., School of Public Health, University of Michigan, Ann Arbor, Mich., 1948. 181 pp., and appendixes, 42 pp. Single copies free. Write to Bureau of Public Health Economics, School of Public Health, University of Michigan, Ann Arbor, Mich.

It is timely that a book such as this should be written now, so that the many valuable lessons learned in this wartime medical-care program will not be lost in Federal and State files. The authors were well-equipped for the study by their understanding of the fundamental principles involved in plans for provision of medical services. Their book is evidence of their grasp of the complicated administrative problems arising when a wartime medical-care program had to be developed rapidly, without prior patterns for guidance and without time for negotiation and discussion. The authors have done an admirable job in evaluating the strengths and weaknesses of EMIC, and the book gives the reader an insight into the conflicting viewpoints of vendor and beneficiary, as well as administrator.

The study begins with an account of the establishment of the Children's Bureau and the expansion of its functions to include administration of grant-in-aid State programs under the Social Security Act. As a sidelight, the story of EMIC illustrates how the democratic process works—how the Congress acts in response to needs of the people and how controls over Federal agencies are set up by the Congress, by the President and the Bureau of the Budget, and by the Attorney General, and how these controls are passed on to the States.

The book can be recommended to those who are concerned in the development or administration of medical- or hospital-care plans, as well as to participants in such plans.

Alice D. Chenoweth, M. D.

A limited quantity of each of the following items, reprinted by the Children's Bureau from sources outside the Bureau, is available for distribution. Single copies may be had without charge.

Group-Casework Experiment with Mothers of Children with Cerebral Palsy. By Regina Elkes. *Journal of Social Casework*, March 1947.

The Premature Infant Program in Colorado. By E. Stewart Taylor, M. D., and Harry H. Gordon, M. D. *The Mother*, Quarterly Bulletin of the American Committee on Maternal Welfare, October 1948.

Terminal Heating of Infant Formula. Three articles reprinted from the *Journal of the American Dietetic Association*. The titles and series numbers are as follows:

I. Bacteriological Investigation of Low-Pressure Technique. By F. R. Smith, R. D. Finley, H. J. Wright, and E. A. Louder (September 1948).

II. Bacteriological Investigation of High-Pressure Technique. By R. D. Finley, F. R. Smith, and E. A. Louder (September 1948).

III. Retention of Heat-Labile Nutrients. By A. Z. Hodson (February 1949).

Maintaining Foster Homes Through Case-Work Skills. By Draza Kline and Helen Mary Overstreet. *Social Service Review*, September 1948.

Nutritional Requirements During Pregnancy and Lactation. By Bertha S. Burke, M. A., and Harold C. Stuart, M. D. *Journal of the American Medical Association*, May 8, 1948.

Potentialities and Limitations of Prenatal Pediatrics. By Clement A. Smith, M. D. *Journal of the Michigan State Medical Society*, April 1948.

THE CONTRIBUTION OF PHYSICAL THERAPY TO NURSING EDUCATION; prepared by Subcommittee on the Utilization of Special Therapists in the Teaching of Student Nurses, Committee on Curriculum. National League of Nursing Education, 1790 Broadway, New York 19, N. Y. 78 pp. $1.25.

A need has long been felt by both nursing educators and physical therapists for some guide whereby the technical knowledge of the physical therapist applicable to basic nursing education could be better utilized.

Therefore, in 1946, the Committee on Curriculum, National League of Nursing Education, appointed a subcommittee to study the contribution of physical therapy to basic professional education. Work committees consisting of nurses and physical therapists were established to study outlines of nursing courses, teaching methods, and clinic experience in the fields of health of student nurses, nursing arts, medical and surgical nursing, pediatrics, obstetrics, psychiatry, and basic sciences. This pamphlet, which is in outline form, is a compilation of the material submitted by these work committees.

The outlines are not intended to furnish content for lesson plans, but they do give enough detail to serve as a means of orientation and guide for the nurse instructor and the physical therapist. The contribution of the physical therapist, the report says, should be made wherever possible as adviser to the nurse instructor or supervisor rather than in the form of direct teaching of students.

While the contribution of physical therapists is emphasized, other professional personnel are also suggested; these, the subcommittee feels, can contribute to the principles of body mechanics and posture in the basic nursing curriculum.

This pamphlet should be of particular value to nurses and physical therapists interested in basic nursing education. It should also be of interest to those responsible for in-service education of professional staff in hospitals and public-health services.

Clara M. Arrington

OCCUPATIONAL OUTLOOK HANDBOOK; employment information on major occupations for use in guidance, prepared in cooperation with Veterans' Administration, Office of the Assistant Administrator for Vocational Rehabilitation and Education. Bulletin No. 940, Bureau of Labor Statistics, U. S. Department of Labor, Washington, 1948. For sale by Superintendent of Documents, Government Printing Office, Washington 25, D. C. 454 pp. $1.75.

Young people and others who are choosing a career or a course of training need current information on employment trends and outlook in the various occupations, says Ewan Clague, Commissioner of Labor Statistics, in his introduction to this handbook.

The book gives such information for 288 occupations. Included are jobs that represent 80 percent of the employment opportunities in professional and semiprofessional occupations; 75 percent in skilled occupations; 40 percent in clerical occupations; 30 percent in service occupations; smaller proportions of employment in other fields; and the major types of farming.

The report on each occupation describes the job and gives data on the chances for employment, the training and qualifications required, and the earnings and working conditions.

The handbook covers agriculture by describing job opportunities in several types of farms in each of the 10 major regions of the United States. The agricultural section was prepared by the Bureau of Agricultural Economics, Department of Agriculture.

In preparing this book, the Bureau of Labor Statistics worked with nearly 3,000 trade associations, unions, private employers, and other groups.

ORTHOPSYCHIATRY 1923–1948; retrospect and prospect. American Orthopsychiatric Association, Inc. 1790 Broadway, New York 19, N. Y. 1948. 623 pp. $8.50.

Along with the growth of the organized practice of pediatrics in this country has grown the specialty called orthopsychiatry, and an organization of those who practice it.

This organization of about 700 members is called the American Orthopsychiatric Association. It includes child psychiatrists, psychologists, and psychiatric social workers. These serve the same age groups as do pediatricians, and are involved in the same functions of prevention and treatment of problems affecting children.

To commemorate its 25 years of existence this association has published an omnibus volume giving the history of the work in this field, the aims of the workers, and the obstacles they see to future progress.

Since the entire book concerns itself with work done and planned for children, it should be of interest to workers in many professions. The viewpoints of several professions are separately outlined, with two presentations of the relations of pediatrics to orthopsychiatry. One of these gives the viewpoint of the psychiatrist; the other, that of the pediatrician. Throughout the book we see evidence of how psychiatry has been a force in changing pediatric methods in the care of the child.

The book is manifestly too long to be read at one sitting, but the separate chapters make excellent browsing. In addition to the series of chapters in the section called "Interpenetration of Disciplines," the concluding chapters of the book, on "Functions and Practices," are highly practical. Any worker interested in his relations with the public should not miss the final chapter on "Mental-Hygiene Education," by Nina Ridenour.

Henry H. Work, M. D.

• CALENDAR

Aug. 23–27—American Occupational Therapy Association. Detroit, Mich.

Aug. 29–Sept. 1—The American Legion. Thirty-first annual national convention. Philadelphia, Pa.

Sept. 6–10—American Psychological Association. Annual meeting. Denver, Colo.

Sept. 12–16—Thirty-first National Recreation Congress. New Orleans, La.

Sept. 26–29—American Hospital Association. Cleveland, Ohio.

Oct. 10–14—American Dietetic Association. Annual meeting. Denver, Colo.

Oct. 17–20—National League to Promote School Attendance. Thirty-fifth annual convention. New York, N. Y.

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Pages 6 and 7, Angela Calomiris for U. S. Committee for the Care of European Children.

Page 8, courtesy of U. S. Committee for the Care of European Children.

Page 9, Philip Bonn for Office of Education, Federal Security Agency.

WE WELCOME DR. BAUMGARTNER

Leona Baumgartner, M. D., became Associate Chief of the Children's Bureau on June 2, 1949. Dr. Baumgartner succeeds Dr. Martha M. Eliot, who, after a quarter of a century in the Children's Bureau, left us at the end of May to become Assistant Director-General of the World Health Organization.

Dr. Baumgartner comes to us from the New York City Department of Health, in which she served for 12 years. Her first position in that department was that of a district health officer: her most recent one, assistant commissioner of health.

In the 8 years between those two jobs Dr. Baumgartner directed the bureau of child hygiene, of the department of health. As director of that bureau she supervised not only the health services that the department provides for mothers and children, but also all of New York's day-care agencies and children's institutions, as well as foster-family homes.

Dr. Baumgartner was born in Chicago, Ill., and grew up in Kansas and the State of Washington.

She went to college at the University of Kansas, and received both the A. B. and the A. M. degrees from that university, specializing in bacteriology and immunology.

Her medical degree is from the Yale University School of Medicine, and she has a Ph. D. in public health, also from Yale. At Yale she held the Sterling and the University fellowships for research. Later she spent a year doing research at the Kaiser Wilhelm Institute at Munich, Germany. Before engaging in public-health work Dr. Baumgartner had several years of experience in high-school and university teaching.

Dr. Baumgartner is certified as a pediatrician, and has been on the pediatric staff of New York Hospital. She is Assistant Professor of Pediatrics, Public Health, and Preventive Medicine at Cornell Medical College, New York City, and is licensed to practice medicine in New York State.

A few years ago, at the invitation of the French Government, Dr. Baumgartner spent some time in France as adviser on child health to the Ministry of Health.

The University of Kansas Alumni gave Dr. Baumgartner their 1947 Distinguished Service Award for a fellow graduate, and in 1945 she won the American Design Award for creative work in designs for living for children.

A member of the Executive Board of the American Public Health Association and chairman of its committee on child health, Dr. Baumgartner is also a member of the American Academy of Pediatrics and of the American Pediatric Society.

Dr. Baumgartner is no stranger to the Children's Bureau. She has been a member of some of our advisory committees, and has been a member of the National Commission on Children and Youth ever since it was created 7 years ago as the Children's Bureau Commission on Children in Wartime. Readers of *The Child* are familiar with her work.

Inducting Dr. Baumgartner into office, Oscar R. Ewing, Federal Security Administrator, said: "Dr. Baumgartner brings to the far-flung health program of the Children's Bureau a leadership that has been enriched and matured by distinguished service to a community. She knows what it means to organize and maintain prenatal clinics, well-baby clinics, school-health services, and the many specialized treatment services that mothers and children need for good health. Her practical knowledge of how to do a community health job will be immeasurably valuable in the Children's Bureau and to all of us in the Federal Security Agency."

In these words Mr. Ewing speaks also for the entire staff of the Children's Bureau, as we welcome our new Associate Chief.

Katharine F. Lenroot

Chief, Children's Bureau.

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CHILDREN'S BUREAU
Katharine F. Lenroot, Chief

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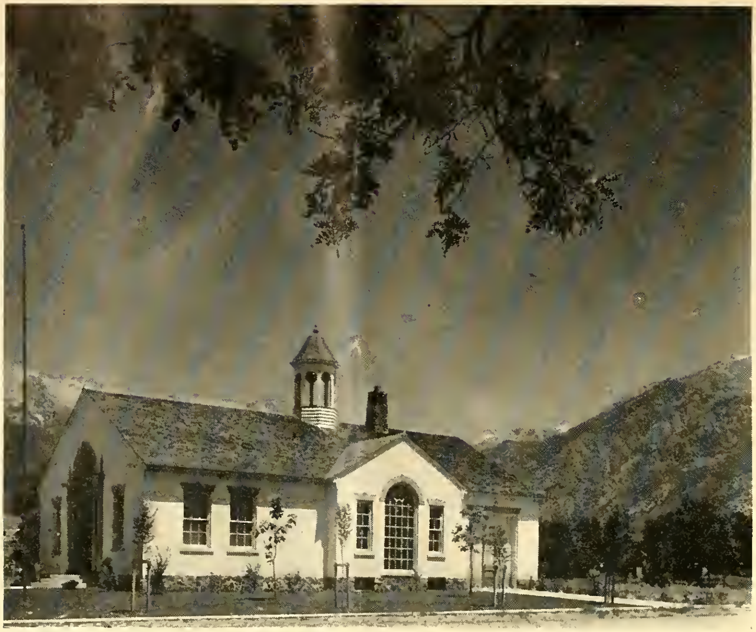
the CHILD

EASY TO DRAW
A PRE-SCHOOL BOOK



THE CHURCHES' RESPONSIBILITY TO CHILDREN

KATHARINE F. LENROOT*, Chief, Children's Bureau*

THE GREAT ISSUES with which the human race is grappling are essentially spiritual issues. Is a man to be regarded as a child of God, or as a product, possibly accidental, of a process that may be described perhaps in terms of mathematics, but never in terms of divinity?

Is the aim of human society the development of personality, or the absorption of life and thought in an all-embracing state? Is man's personal conduct to be judged by the measure of his integrity, or of his success?

How are the concepts and requirements of human freedom, social necessity, political and social security, and social justice to be evaluated, and to be related one to the other?

How can religion's concepts of charity and of responsibility for one's neighbor be applied to industrial relations, to interracial problems, to government, and to international tensions and intercourse?

These are questions that relate to the policies and programs of the United Nations, to the legislation of Congress and of the States, to the activities of our town and our parish, to the face-to-face contacts of men, women, and children, in homes, workshops, schools, churches, and places of amusement.

The issues of war and peace, prosperity and depression, freedom and authority, can be solved only in the measure that moral stature and spiritual strength are developed in people. To quote the fundamental principle of UNESCO, "Since wars begin in the minds of men, it is in the minds of men that the defenses of peace must be constructed."

Aims of our democracy in relation to children

What opportunities do we seek for our children, and what characteristics and qualities of body, mind, and spirit do we wish to see developed in them? These are questions on which the churches have a great contribution to make. The answers must be related to certain basic concepts and facts about childhood. Some of these have been stated as follows:

1. The child's personality is molded in earliest infancy and childhood.

2. The child's growth in ability to relate himself to the outside world and to other human beings is inseparable from his physical and mental growth and development.

3. The outgoing, enfolding, unselfish love of emotionally mature parents is the soil in which the personal security of the child grows.

The child's security in his family relationships is the foundation for his growth toward maturity in all human relationships.

4. Each child has his own rhythm and his own rate of growth, which must be considered in relation to all the aspects

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Based on paper given at Church Conference of Social Work, June 13, 1949, at Cleveland.

of his training and education in the home, the school, the church, and the community.

Regard for human personality demands regard for each child in each stage of his growth.

5. Next to the child's need for security is his need for an example, a pattern by which he will build as he grows in experience and independence of thought and action.

We must not only give children emotional security; we must enable them to identify themselves with parents, teachers, and religious and civic leaders who are united in a great effort to establish a social order throughout the world based on the dignity of the free man and his responsibility for the common good.

6. In other words, each child must learn to relate his ego drives and needs, not only to his own family and associates and to his own culture, but to other cultures and the world at large.

Preparation for intercultural and international understanding and cooperation is as essential as is preparation for family and vocational life.

To what extent are we basing our policies and practices in week-day and church schools, health, social-service, and recreational agencies, on what is known about children and their needs and on the goals in child rearing and education that we should strive to attain?

What means do we have for testing the extent to which our attitudes and practices in home and church life and community services are in conformity with sound principles of child rearing and education? If great gaps and weaknesses in our programs and policies are revealed, how can we convince ourselves and others of the need for change, and how can we develop out of research and experience more adequate programs which will receive widespread support?

What the churches can do

What churches can do for children and young people may be considered under these headings:

1. Developing in church people an underlying philosophy, point of view, and conviction about children and their needs.

2. Giving direct services to children and their parents, through the life and work of the church.

3. Participating in community planning and community services.

4. Offering special child-care and child-welfare programs under church auspices.

5. Taking social action in relation to national and international policies and programs.

Underlying philosophy and conviction about children

In the Book of Revelation the Evangelist was directed to write to the angel of the church in Laodicea: "I know thy works, that thou art neither cold nor hot: I would thou wert cold or hot."

Probably most of us, for most of our lives, are in this state of lukewarmness about the things that matter most in their effect on the future of civilization.

We in this Nation will go to any lengths to save an individual child caught in a well, or suffering from leukemia, or in need of skin-grafting to prevent death from burns. It is not so easy to arouse us to deal with problems that seem less personal. Somehow we fail to harness sufficiently our love and concern for children to organized effort to provide for all children the things that are essential to their welfare and development.

Just now—the season for summer camps—the cooperation of citizens is being enlisted in most of our great cities to make it possible for underprivileged children to go to camp. (Would that all city children could have such opportunities!) When church people read these pleas for summer camps, to what extent do they ask themselves what could be done to see that children living in wretched slums, without enough to eat and without a chance for wholesome recreation, could have clean beds, full stomachs, and safe play, throughout the year as well as for 2 glorious vacation weeks?

Again, there is the great need of services to improve the health of mothers and children. These services are almost everywhere inadequate, but particularly so in rural districts removed from metropolitan centers—and two-thirds of the counties in this country are in that class. The American Academy of Pediatrics, after a Nation-wide, State-by-State, and county-by-county study of child-health services with the cooperation of the Children's Bureau and the Public Health Service, says: "How to make

Security in the family group helps a child to become mature in his other human relationships.

good medical care available to all infants and children, no matter where they live or what their circumstances, is the number one health problem of this country."

Another great problem that affects children lies in the extreme shortages that exist in the services of social workers able to deal helpfully with children's problems. Only 1 out of every 5 counties in the United States has the full-time services of a child-welfare worker. No Federal funds are available for the care of children in foster-family homes, except for a few temporary projects. State and local funds now available are too small to assure good care to all children in need of foster-family care and to recruit an adequate number of foster-family homes. For these reasons children are left in unsuitable homes, or are cared for during long periods in institutions. Many children are kept in jails or in other unsatisfactory detention quarters, for lack of suitable detention facilities.

There is great need for enlarged and enriched programs of recreation and leisure-time activities under the leadership of qualified workers.

Employment counseling and placement services for youth should be multiplied and strengthened.

There is need for tightening up and strengthening Federal and State child-labor laws.

Expanded funds for research in child life and for training professional workers in all fields of service to children are urgently needed.

Progress can be made in dealing with these and many other problems, including expansion and enrichment of educational opportunities, only if citizens are fully aware of them and are committed to the necessity of doing everything possible to see that every child born under the American flag, regardless of race, creed, color, geographic location, or economic circumstance, has his fair chance in the world. The churches have unequaled opportunity to create such awareness and stimulate such commitment in their membership.

Direct services to children

Great progress has been made in church schools, as in day schools, in developing the educational program around the growing child and his needs, instead of emphasizing a purely informational or instructional program. Church schools are frequently handicapped in their resources for obtaining leaders and teachers equipped with sufficient understanding of child growth and development as well as in the special subject matter of religious education. Much is being done through city-wide institutes and special services of other kinds, as well as through the development of written material and other devices for leadership training. Much more can doubtless be done in utilizing community resources under the auspices of schools, universities, child-study centers, and child-guidance clinics to enrich the religious-education programs of churches.

The growing demands upon churches for individual service through family and personal counseling by the pastor or his assistants open up an important avenue for strengthening the home in its functions of child nurture, and for linking up the home and the church school in an effort to meet more fully the needs of individual children and young people. Such counseling service is an important means for encouraging the intelligent and constructive utilization of community resources for educational, health, and social services.

In exploring what might be done on the subject of the religious needs of children in preparation for the Midcentury White House Conference on Children and Youth, it has been suggested that if the churches themselves could examine and analyze their own programs in relation to children they could contribute greatly to the purpose of the conference enterprise. How are they contributing to the needs of children for security in a rapidly changing world, the security that comes not only from a warm family life but from faith in a loving God? How are they helping children to develop a pattern of concern for and sharing with others, in church, community, intercultural, and international relations?

Many interesting and valuable demonstrations are being made by churches in these aspects of Christian education. A church in the District of Columbia has a fireside group of young people that has just won one of three national awards in "Adventures in Christian Fellowship," sponsored by the National Conference of Christians and Jews and the Board of Christian Education of the Presbyterian Church in the United States of America. Awards were presented to church groups for outstanding programs, during a 2-month period, contributing to better understanding of those of different racial, religious, and cultural backgrounds.

It is important that churches try to reach children among the most disadvantaged groups within the community—the children of migrant agricultural workers and other children lacking in opportunities for normal home and community life; the children coming before the juvenile court; those in detention homes and institutions; those under the care of agencies for homeless, dependent, and neglected children; the handicapped; and the sick. Interchurch cooperation as well as cooperation with public and nonsectarian agencies will be necessary in such undertakings.

Participation in community planning and community services

The direct services that have been described lead to the general participation of churches in comprehensive community planning and the development of community services for children and young people.

During the last decade there has been great emphasis on neighborhood, community, State, and National review of children's needs, evaluation of services, planning of programs, and action to obtain better provisions for the health, education, and social welfare of children. It has been recognized that official and voluntary agencies, church organizations, and citizen groups must be included in such planning and must cooperate in achieving results.

Since 1942 the National Commission on Children in Wartime and its successor organization, the National Commission on Children and Youth, have given national stimulus to these efforts, in cooperation with the Children's Bureau of the Federal Security Agency, other Federal agencies, and nongovernmental organizations. Leadership has been given also by the National Social Welfare Assembly, Community Chests and Councils, and many individual national bodies. Representatives of church groups have participated actively in the work of the National Commission on Children and Youth.

The National Commission initiated the movement for a Midcentury White House Conference on Children and Youth, and recommended a period of preparation for the conference that should include a program of action by States and communities. It urged that this program enlist the widest possible participation of citizen and professional groups, and that in each State and Territory leadership be given by a Statewide representative planning body.

Thirty-two State planning groups for children and youth have been concerned with White House Conference planning in 28 States and the District of Columbia, and it is hoped that all the States will have such leadership by next winter. One of their main objectives will be to stimulate discussion and planning in local communities. Churches should follow these developments closely and find ways of sharing in making 1950 a year of focusing the attention of the entire Nation on children and their needs.

Experience has shown that churches can be of major help in interpreting need, securing public and private funds to finance services, promoting adequate standards of service and the use of qualified personnel, and enlisting volunteers to reenforce and complement work done by paid staff. The program of this conference constitutes recognition by the churches of the importance of these areas of work.

Special child-care and child-welfare programs

The churches' concern for children early found expression in the establishment of institutions and child-placing agencies to care for children who were orphaned, abandoned, homeless, or in need of special care and protection for other reasons. Large numbers of children today are cared for by organizations conducted under church auspices. Many of them have pioneered in providing financial aid to mothers to enable them to keep their children with them and in developing foster-family homes and cottage-plan institutions.

It is important that the values provided and the experience gained through such efforts be fully conserved and utilized. At the same time, the churches have for the most part recognized the necessity of relating their programs to changing needs, gearing in with comprehensive community services and stimulating public responsibility as required to insure that all children have access to the services they may require, and that all child-caring organizations be conducted in accordance with acceptable standards.

Social action

There are many ways in which churches and church members can directly and indirectly help to formulate and implement national and international policies and programs relating to children and youth. It is important that proposals pending in Congress affecting housing, education, health, social security and social welfare, research, and other aspects of our life, both those relating to the population in general and those specifically directed toward children and young people, be understood, analyzed, and discussed by church people. There is often room for real difference of opinion concerning methods, but none concerning objectives; and all of us should recognize the importance of moving forward vigorously to resolve differences and achieve results. It is of the utmost importance in international affairs to support and extend international cooperation in matters pertaining to the health, education, and welfare of children, as well as in other fields of scientific and cultural endeavor.

Throughout the wide variety of international, National, State, and local effort taking place during the next 2 years in relation to children and youth, there should run a single thread of purpose. We should test all our services for children by our understanding of what is necessary to make it possible for them to grow into the kind of people in whose hands will be safe the values we cherish because of our faith in God and our belief in personal freedom and social responsibility.

Thirty years ago Julia C. Lathrop, first Chief of the Children's Bureau, called child welfare "a test of democracy." We shall be judged by the peoples of other cultures to a large extent by the degree to which we make this American dream a reality. They will be helped to understand us as they sense our sincerity and our courage in advancing toward our goal of equal opportunity for all youth.

Reprints in about 4 weeks.

We need larger and richer programs of leisure-time activities under qualified leadership.

TWO NEW YORK AGENCIES TRY OUT GROUP HOMES FOR ADOLESCENTS

AUDRE T. DELANY, *Executive Director, Riverside Children's Association, New York City*

CHILDREN who need foster care—children who cannot be in their own homes with their own parents—do not all need the same kind of foster care. That has been learned by workers in the field of child welfare in the long process of studying the effect on children of placement away from home.

For some children neither foster care in an institution nor foster care in a family has proved suitable. A type of foster care that is emerging, to give these children a home, is group living in small units outside institutions. These group homes seem to be a good setting for these children—something between family life and institutional living.

In a recent issue of *The Child* a group home in Baltimore was discussed, which, in size, leaned toward the small institution. Here are discussed two more variations of group homes, in New York, these tending to be of family size.

These two projects in group living, noninstitutional and small-scale, came into being for different reasons and illustrate different settings for this way of giving suitable homes to children who cannot be in their own homes yet do not fit into the usual type of foster care. One is the project of the Jewish Child Care Association, the other the project of the Riverdale Children's Association, a Protestant agency. Both are relatively new.

The idea goes back three decades

In considering these examples we should not think of this form of group living, now more prevalent, to be sure, than in former days, as an entirely new idea in New York. As far back as 1916 the Hebrew Orphan Asylum set up a small group home to give certain of the older girls in its institution a chance to live away from the institution in a setting that had some of the qualities of a real family home. This pioneer effort, a recognition that institutional living had limitations as a setting for some children, became a nucleus for the planning of group homes that followed.

In the 30 years or so since the establishment of this group home our understanding of children's needs has gradually developed and we have gained a clearer insight into the part played in casework treatment by the choice of a placement setting. That is, we have learned that different children need different kinds of foster care. This knowledge has resulted in improving the organization of our institutions in the direction of making life in them more homelike, in strengthening their programs, and in appraising more realistically the potentialities of foster care in institutions and in family homes. The knowledge has brought about better services for the children who can benefit from these two types of care.

But what of the children who cannot get along in either setting—institution or family home? All workers in the children's field know some of these children well. We know that they have had many unsuccessful family-home placements, climaxed by equally unsatisfactory periods in institutions.

Necessity produces action

In the experience of the Jewish Child Care Association and the Riverdale Children's Association, the necessity of planning for these children whose needs could not be met by the existing types of care gave the impetus to developing a different living setting, the group home.

The first-named agency added this new approach and function to a long-established program. The latter agency developed its project as a new venture, stimulated by the need for making special plans for two groups of children when the agency closed its institution. They were a number of adolescent boys and girls and several younger boys. The plans made suggest two approaches to the placement of certain children and will be considered separately as such.

A group of nine girls

"Friendly Home" is the name of the group home developed by the Jewish Child Care Association. Being chosen to live there was originally a reward for the exceptionally well-behaved girl in the institution; now it is a chance for adolescent girls to work out their emotional problems that make living in their own homes, in family foster homes, or in an institution intolerable to them. At first the home's method of procedure was a conscious educational process of homemaking, that is, of teaching the household arts. This has changed to a procedure that aims to create a place in which the atmosphere is neutral—suggesting neither side in any conflict a girl might have had before coming there. It is planned as a place in which a disturbed adolescent can live with a sense of security and a feeling of being acceptable to those she lives with while she attempts to understand her mixed feelings about her own family and about her place in society.

The usual age at admission is 15 years or a little older. The placement is regarded as for a short time only, the maximum stay being about 2 years.

The residents of Friendly Home are eligible for all the services of the association unit that maintains the home. All have casework service consistently; and when necessary they have medical service, including psychotherapeutic treatment, and dental service, as well as vocational guidance. These services and the friendly, make-your-own-choice atmosphere of living at the home often help a girl to establish better relations with her own family and frequently to return home. When returning home is

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Based on a paper read at the seventy-fifth annual meeting of the National Conference of Social Work.

impossible, this experience in group living may help a girl gradually to accept the idea of some other way of living, such as in a boarding home or a girls' club.

The setting

Friendly Home is an ordinary, ten-room apartment, comfortable and big enough to house nine girls. It is close to lines of rapid transportation, a convenience that is important in a city the size of New York, where no group, even a family, can find in one neighborhood the resources to meet its various needs and interests.

By means of subway, elevated line, or bus, the girls in Friendly Home may combine such activities as attending school, working part time, keeping in touch with friends who live at a distance, and enjoying a recreational center that is several miles away. Having this large community to move about in and to choose activities from has been an important factor in the solution of various emotional problems.

Ample living space is afforded to help avoid the friction inherent in too-close living. The young residents and the staff live together as a unit, sharing the use of the apartment fully. The girls regard the apartment as their home, and the agency imposes few restrictions on their use of it.

The staff

The home is wholly maintained by the Jewish Child Care Association. It is directed by a house mother—usually called the group-home mother—who has had training in home economics and wide experience in group social work.

In addition to the many duties she performs in carrying out the day-by-day household activities of the home, the group-home mother also conducts a homemaking project with the group. She sees that the girls learn to market and to prepare and serve meals, and she guides their efforts to have a good time socially—both inside and outside the home.

The director has an assistant to whom she assigns responsibility for some of the household duties and who assumes full direction when the group-home mother is off duty. They have supplementary help for the heavy work.

The caseworker acts as liaison between Friendly Home and the unit of the association that administers the home. She is in close touch with the head of the unit as well as the chairman of the committee of the board of directors that is responsible for Friendly Home. She attends board-staff committee meetings at which policies and procedures for the home are decided on. She shares with the staff member responsible for "intake" this work of deciding which girls shall be accepted as residents of the Friendly Home.

The girls' response to the home

Besides doing part of the general housework, the girls are expected to do their personal laundry, make their beds, and tidy their bedrooms. This work they perform with different degrees of competence. The unevenness is due partly to the general characteristics of adolescents and partly to their own emotional instability.

In general, the residents tend to take the home for granted and to be unable to put much interest or sustained effort into its upkeep. The staff makes no issue of this attitude among the girls, which is usually expressed in failure to make their beds, in breaking equipment, or in dodging tasks altogether. The minimum standard of cooperation in these matters that all must face is a performance that makes it possible for the group to tolerate a fellow resident under the conditions of group living.

The residents do not constitute an integrated group, although close companionships between two or more girls do sometimes develop. Most of the girls seem to have little desire or need to cling together or to engage in common activities. This is true even of those who had known one another previously at the institution. An outstanding exception to this marked independence of action is the celebration of birthdays, always a gay occasion, with everyone taking part with apparent enjoyment.

The agency, fully recognizing the girls' individual differences, does not force any group activities. An example of this is the giving up of the Friday Sabbath-eve observance when it became evident that the girls had other interests that meant more to them. Formerly this was the one occasion for which all the girls were expected to be at home together at the dinner hour.

Disagreements and quarrels occur, as would be expected. The group-home mother lets the girls settle them themselves, interfering only if there is danger of bodily harm. Undesirable behavior like stealing, staying away from school, and staying out beyond the agency curfew is referred to the caseworker and only she handles these matters.

The staff makes every effort to avoid precipitating a crisis in the home that would require disciplining any of the residents. The form of discipline would be difficult to determine, might create a situation even more serious than the first difficulty was, and might endanger the position of neutrality that it is advantageous for the group mother to maintain.

The JCCA evaluates the home

From its experience with Friendly Home, the Jewish Child Care Association thinks that this arrangement provides an unusual opportunity for the girls in the home. So beneficial has the unit proved itself that a boys' group is to be established soon. As with the girls' home, boys will be considered from various backgrounds—boys with whom the agency has been working in their own homes or elsewhere, perhaps in hospital; boys who have been in an institution or in family foster care and need a different setting; and boys who have never before been served by the agency.

The strength of this way of living—in a small group—is felt to come from two sources. Strength lies in the assurance given to the young people by their realization of the similarity between their experience and the experience of others in the group and by the free and easy atmosphere, akin to that of a natural home. Strength lies also, of course, in the skilled, almost imperceptible supervision given in the living process as well as in the casework service.

When an institution closed

Let us turn to the experience of the Riverdale Children's Association, on whose staff the writer serves. The experience is different from that of the other agency in a number of ways.

The Riverdale Children's Association organized group homes in 1946 when it closed the institutional phase of its program, as has been said before. The homes were to provide a suitable form of living for a particular group of children who could not be placed in family foster homes. Many of them were too deeply involved emotionally in their relations with their own parents, either because of their separation from them or some other reason, to be able to accept substitutes for them. Others found the demands of the usual relations between parent and child too painful to be tolerated. Some of the teen-age young people, anxious to attain adult status, found parental authority completely unacceptable. Placement in another institution, even if openings had been available, was not the answer either.

There were points that would help in making a decision. These children seemed to have the capacity to adapt themselves to the demands of community living; many were already attending outside schools and were reaching out for broader experiences than they could have in an institutional setting. Also, many were approaching the age when they must be ready to support themselves and to meet whatever happened to them without the support of the agency. These children had shared a group experience in the institution, finding security and satisfaction in their relations with companions of the same age. Certain of them had expressed the desire to continue to live with particular friends when they left the institution.

To use group-home experience

As soon as we of the association staff knew that the institution was to be closed, we began to consider how the experience there, which had so much meaning for certain children, could be utilized in some other setting. We considered establishing a small home patterned after Friendly Home. But the large size of the group and the fact that it included both boys and girls—children of widely different ages—made such a plan administratively and financially impossible. So we decided to attempt to combine some of the aspects of family foster care and group living.

We were not altogether inexperienced in this sort of care, because our family foster homes for temporary care accommodate several children at a time, and we have also worked with those foster mothers—rare as they are—who have the ability to substitute for the parents of several unrelated adolescent children.

Guiding principles

Knowing of no procedure already worked out and published by another agency and having no exact experience of our own to guide us, we formulated six general principles setting forth the kind of group foster homes the agency wished to try to develop. These principles are:

1. We should seek private homes belonging to and maintained by boarding parents in which the agency would place no more than six children.

2. Determination of the suitability of any particular child to remain in the group he was placed with would be the joint responsibility of the caseworker and the group mother, but the final decision on placement in and removal from a group home would be made by the agency, after considering the recommendations of various members of the staff.

3. No attempt would be made to approximate the age range of an actual family. The group might or might not consist of children of the same age.

4. The foster parents would be paid for their services, the amount of compensation to be about the same as that paid currently to cottage parents in the institutional programs of the community.

5. The regular agency board rate would be paid for each child in the home (that is, payment to the foster parents of the actual cost of the child's share of the family budget).

6. The same amount of money would be allowed for incidental expenses as would be allowed in the case of other children under the care of the agency; medical and psychiatric services would be made available to them.

The agency recognized the practical necessity of supplying the home with such basic furnishings as beds and mattresses, because the average prospective foster parents would not have enough of these for a group home. These basic supplies were arranged for, but the agency took no further responsibility for replacements or supplies beyond the budgeted allowance in the monthly board rate.

The group homes open

By means of our year-round homefinding efforts, and a concentrated, community-wide campaign for foster homes, made jointly by three sectarian groups, we managed to stimulate some applications from prospective foster parents who had a special interest in this kind of service. Five group homes were opened in all; three of them were for adolescent boys (one was temporary and in use only a year), one for adolescent girls, and one for younger boys.

Although we had planned to use homes of married couples, only two of the homes, one for girls and one for boys, worked out this way. The couples who did open their homes to these children had already served the agency as foster parents. The difficulty in getting couples to act as foster parents in group homes seemed to be, in general, the husband's belief that caring for a group of adolescents would leave too little time for the family's own activities.

All the group-home mothers were of middle age, had finished raising their own families, and had expressed a desire to help children. They were intelligent, competent women who could manage a household well and were willing to take on this serious responsibility as a full-time job.

Girls and boys were placed in separate homes, as has been said, and the younger boys in a home by themselves. The other criteria for assignment to a home were the suitability of that home for the child and the child's degree of emotional stability. If his instability resulted in its being hard for him to feel interested in and close to other children and to adults, he needed skillful attention and was placed with that need in view. The selections made on these points resulted in fairly homogenous groups in each home.

The agency's appraisal

At the end of 18 months of experience with placing children in group homes, the Riverdale Children's Association has reached a few conclusions. They are, of course, limited in scope because they result from only a year and a half of experience and because the children placed, coming from the same setting, had already formed some natural groupings themselves. We can comment only on the children who entered the group homes from the agency's institutions, not on the children who are now being placed in the homes from other backgrounds. That is because our experience with these latter children is too short.

Three conclusions stand out as we look closely at the effect on the children of living in the group homes:

1. From the beginning the relations between the children and between the children and the foster mothers in the group homes meant a great deal to the girls and boys and had some emotional depth. The children derived a sense of security from being part of the group. The group served to protect them from the pressures outside the home and from uncomfortable situations within the home, particularly any differences they might have with the group-home mother.

The children sought approval from their foster mother in individual ways. She in turn felt somewhat driven from within to help them develop their talents and to achieve a degree of success in school, at work, and in social contacts. Because the children had never had to exert themselves in life outside the institution, they found it difficult to respond to her efforts to stimulate them to action. They tended to cling even more closely to the group and to withdraw from her.

This tendency was halted when the casework help given each child reduced his anxiety about the efforts he seemed to be expected to make and when the foster mother also responded to help from the caseworker. The foster mother learned then to relinquish her activity for the success of the children, relying on the worker to look out for their well-being as a whole.

2. Like the children in Friendly Home, these children were uninterested in the work of keeping the home in good order and careless about the equipment. This lack of interest and of cooperation could not be handled as impersonally in a group foster home as it was handled in a home maintained by an agency as Friendly Home is. The indifferent attitude of the children toward the home was frustrating to the group mother.

One way to relieve the anxiety of the foster mother about the destructiveness of the children seemed to be to increase certain allowances in the budget, especially the amount for replacement of equipment.

3. The caseworker had to assume a great deal more responsibility toward the children in these homes than she usually does in foster care. She had to act more authoritatively and had to be with the children and the foster parents more frequently than is usual in casework treatment.

In addition to these more obvious services, the intensive casework treatment that is necessary for all disturbed children, wherever they are living, had to be given to these boys and girls.

The caseworker was able to work with the group as a whole on problems that were common to the children but that individual children could not bring themselves to talk with her about. For example, the group discussed together the possible value to them of vocational testing. This discussion arose from the anxiety expressed by some of the group about being able to earn a living when they left school—an anxiety obviously felt by all the children.

The homes have helped the children

The specific conclusions just stated are drawn, of course, only from the experience of the Riverdale Children's Association. In general, the staff of the agency has observed thus far that although group foster care in family homes does not provide the children with either the protected setting of an institution or the professional skill of a qualified group-home director, it does have distinct benefits as a living center.

We have seen children who could not fit into the usual foster home using the security of group interdependence to achieve a wider circle of social relations. We have seen these boys and girls, feeling assured of a home, sharing with others in the group the difficulties of adjusting themselves to the people and the experiences they encounter, and freed from the necessity of living up to expectations too high, put down roots in the community while they are solving their individual problems.

We see that some group homes are becoming permanent homes for several of the younger boys not yet in their teens and for some of the older adolescents who have become self-supporting. This is more than we had dared to hope for. It shows that good group foster homes, like individual foster homes, may continue to be of help to young people after the boys and girls have ceased to need the services of the agency. It means, however, that the agency, having fewer group foster-home vacancies, must find new homes for these short-term placements. But for so good a reason—that some young people have found permanent homes—we welcome the arduous task of searching for group foster parents—so hard to find.

Reprints in about 4 weeks.

• QUOTE-UNQUOTE

"For the sake of children we cannot afford to lower our sights. We need the courage that comes from the conviction that we in our country will find the means for giving our children, directly and through their families, the care they need—the care America needs them to have. How else can they be prepared for the large tasks that lie ahead of them?"

Robert Kinney, in Bulletin of the Child Welfare League of America, February 1948.

"There is a happy medium between the rigid methods of ultrascientific baby care, with its lack of human contact and its stern, methodical routine, and the happy-go-lucky, careless, neglectful way of handling infants, the disastrous results of which have been evident in the past. This middle way, which is the sensible and successful one for keeping babies alive and well, has as its first principle the utmost simplicity, both in surroundings and methods.

"A great deal of common sense is needed in handling babies; regularity in feeding, attention to proper methods of hygiene, proper adherence to the rules regarding the right kind of clothing, fresh air, exercise, sleep, and quiet; all are essential, but they must not take the form of rigid routine to be carried out to the exclusion of the baby's human needs. After all, no baby will live unless he has that intimate, human contact which for want of a better name, we call 'mothering'."

S. Josephine Baker, "Healthy Babies," p. vii, Little, Brown & Co., New York, 1920.

TO RESTORE CRIPPLED CHILDREN

EDWIN F. DAILY, M. D., Director, Division of Health Services, Children's Bureau

FOR MORE THAN a decade the Children's Bureau has had the privilege and responsibility of administering Federal grants-in-aid under the Social Security Act to the several States for crippled children's services. During this time, the Federal grants have increased from $3,870,000 to $7,500,000, and the State and local financing has increased to a far greater extent.

The 53 State and Territorial programs vary somewhat, depending upon limitations in State legislation, financing, and resources of professional personnel and facilities.

Each State agency administering the crippled children's program plans in detail what services will be provided and how and where, and submits this plan with an accompanying budget to the Children's Bureau for review and approval before any Federal grants are made. The plan must show that the program meets the requirements of the Social Security Act and also meets regulations of the Children's Bureau, which are provided for in the act.

The Children's Bureau's small staff of medical, nursing, medical social work, nutrition, physical-therapy, and hospital-administration consultants study and evaluate the various services throughout the Nation and advise with the State authorities administering the programs.

The Children's Bureau grants the Federal funds to the States as equitably as possible and makes special grants where needed for training of personnel or for demonstration projects of regional or national significance.

We work directly with educational institutions providing graduate training for personnel participating in the care of crippled children, advise them of the types of courses needed, and approve the use by the States of the Federal grants for scholarships or for acquiring additional staff required for teaching the courses. By the use of special grants we have enabled some of the States to develop small, localized, complete programs of care for children with rheumatic fever, or with cerebral palsy, or with hearing handicaps. These programs are serving as guides to other States that are ready to expand their crippled children's programs into these fields.

From our observation and study of these State programs over the years we believe the following principles of administration have resulted in the best type of services for these handicapped children:

What agency and staff are needed to administer a crippled children's program?

The governmental agency responsible for direct administration and operation of other public-health services is, we believe, the best suited for administration of crippled children's programs.

Although services for crippled children must be related to child welfare, education, and vocational rehabilitation, the major fields are those professionally related to health; that is, medical, dental, nursing, medical social, nutrition, and physical therapy, which are all a part of other public-health services.

A crippled children's program should be administered by a competent physician, preferably with graduate training in pediatrics and public health. Orthopedic surgeons, plastic surgeons, pediatricians, nurses, physical therapists, medical social workers, nutritionists, speech therapists, and other professional

In all the details and complexities of administering a crippled children's program we must always remember that our purpose is to restore the health of the individual crippled child.

Given at the First Inter-American Conference on Rehabilitation of the Crippled and Disabled, held at Mexico City, Mexico.

staff will be needed in varying numbers for the supervision or provision of services under the program.

What should be the legal or administrative definition of a crippled child?

The legal or administrative definition of a crippled child should be very broad, and not restricted to a limited number of handicapping conditions. Lack of personnel, facilities, or resources may force an administrator at times to provide care for only a portion of the children in need of care, but he should always be free to accept for treatment the children most in need of care. The definition of crippled children recommended by the Children's Bureau is as follows: "'Crippled children' means those children who are handicapped or suffering from conditions which may lead to being handicapped."

Many of the State crippled children's programs were initially limited to orthopedic conditions, but now, with additional resources, they include children with conditions requiring plastic surgery, with rheumatic heart disease, diabetes, cerebral palsy, hearing and visual deficiencies, and many other handicapping conditions.

Who should have responsibility for assuring care of crippled children?

We believe that a governmental agency should have the responsibility of assuring every crippled child all the services necessary to restore him to maximum physical and mental health. This, however, should not be interpreted to mean that only public agencies should be concerned with services for crippled children. But a public authority should know of all the resources available for the care of crippled children; it should, at the National, State, and local levels, take leadership in coordinating such resources, and should assure the provision of whatever services are needed by crippled children.

What should a program for crippled children include?

We believe that no crippled children's program should be initiated that does not provide the fullest possible range of services within available personnel and resources.

For example, diagnosis alone, hospital care alone, or just convalescent care, will not provide a sound basis for an expanding crippled children's program.

A successful Federal-State program for crippled children will assure to every crippled child in the State the greatest possible restoration of his physical and mental health.

Attention to the child's medical condition only, without equal concern for social factors related to the individual's health, will never achieve his maximum restoration to health.

When it is necessary to limit services it is better that such limitation be done according to type of medical condition accepted, or by decreasing the size of the area served.

Every crippled children's program, whether large or small, should fulfill the following five requirements.

Such a program should include provisions for finding crippled children.

It should provide, for such children, diagnostic and treatment services. These services should include medical care and hospitalization. They should also include convalescent-home and foster-home care, appliances, and follow-up after the child returns home. All this is intended to assure crippled children the maximum restoration of physical and mental health.

A program for crippled children should develop and improve standards and techniques relating to the provision of such care and services for crippled children.

Such a program should also provide for training of personnel.

And lastly, it should provide for the

necessary administrative services for carrying out the program for crippled children.

What about advisory committees?

The most valuable help that a good administrator can have is an advisory committee, composed about equally of representatives of the professional groups concerned with the provision of care under the program, and of citizens (nonprofessional) who can best represent the interests of the public served by the program.

The Children's Bureau has such an advisory committee helping us to form the major policies for developing and administering the crippled children's program. In addition to representatives of all the appropriate professional groups the committee includes individuals speaking for the labor unions, farm groups, parent-teacher organizations, minority groups, women's clubs, veterans, and other groups of citizens.

Who shall be eligible for services under a crippled children's program?

The sole criterion for determining eligibility for service under a crippled children's program should be: Does this child need the services we can provide? Refusal to provide care because of the place of the parents' legal residence, race, religion, or economic status, has no place in any program whose sole aim is to help the child.

In some States a child cannot be taken care of because the family has not lived in the State for a year. In another State no crippled child can be cared for unless the local judge issues a court commitment. Some people still believe that the color of a child's skin should influence the decision to provide him the care needed. All such restrictions are, we believe, contrary to the inherent rights of individuals.

What should be the quality of care for crippled children?

Professional staff to supervise or provide services to crippled children must be selected from the best trained and most competent obtainable. Only physicians, dentists, nurses, medical-social workers, physical therapists, and so forth, who are unquestionably competent to provide the services needed, should be employed by the agency administering a crippled children's program. The full-time staff of the agency administering the program should, like other public servants, be selected on the basis of merit systems of personnel administration. When competent personnel are not available it is usually best to train the needed personnel before proceeding with the program. Only hospitals and convalescent homes meeting acceptable standards for facilities, personnel, and services should be used in a crippled children's program.

Quality of care also depends upon the full consideration of the individual needs of each child and a continuity of services from the time of diagnosis until the child is restored to maximum physical and mental health.

How should a public agency purchase services (when services are not provided directly by the operating agencies' staff and hospitals)?

A public agency, when purchasing medical, dental, hospital, and related services for crippled children, should pay the full cost of providing such services and not bargain for rates below cost. Bargain rates inevitably lead to bargain quality. Hospitals or professional personnel from whom a crippled children's agency is purchasing care should agree in writing that they will make no charges and accept no payment from such patients or their families. The payments made by the crippled children's agencies should constitute full payment for the services provided.

Keeping information confidential

All personal facts and circumstances concerning individual children must be held confidential by the staff administering the program in order to protect the rights of the patient and his family. Exploitation through publicity of the handicapping conditions of an individual is a serious breach in the confidential relationship between a crippled children's program and its children.

The details and the complexities of administration of a crippled children's program can only be known to those who have had the experience. Adherence to basic principles such as those outlined above will, I believe, assure the development of sound programs of service which will be of the greatest benefit to the individual crippled child we are serving through this program.

• IN THE NEWS

Child Labor Prohibited in Work on Radioactive Substances

Employment of minors between 16 and 18 years of age in workrooms where radioactive isotopes and other radioactive substances, byproducts in the development of atomic energy, are manufactured, used, or stored, has been prohibited by Secretary of Labor Maurice J. Tobin.

The Secretary's order, which became effective July 9, 1949, amends Hazardous Occupations Order No. 6 issued under the child labor provisions of the Fair Labor Standards Act of 1938. Hazardous Occupations Order No. 6, which went into effect May 1, 1942, established a similar prohibition with respect to radium and self-luminous compounds made radioactive. Since some substances used in modern industry are naturally radioactive to a very slight degree and have no harmful effects, the Secretary, in this amendment, specifically limits the application of the order to those substances which, because of harmful radiation, require precautions in handling. In this connection, the order states that experience has demonstrated that minors between the ages of 16 and 18 years cannot be relied upon to take the necessary precautions.

The Atomic Energy Commission is already enforcing elaborate safety precautions in plants and contracting laboratories under its jurisdiction. The order, therefore, will affect chiefly laboratories which are not directly under the commission's supervision but which are buying isotopes and other radioactive substances from the commission in increasing quantities.

The order applies to any establishment subject to the child-labor provisions of the Fair Labor Standards Act, that is, to any producer, manufacturer, or dealer who ships or delivers goods for shipment in interstate commerce.

U. N. Children's Fund Gives Aid in Germany

The military commanders of the American and French zones of Germany have signed agreements with the United Nations International Children's Emergency Fund (UNICEF) to make effective the extension of a $1,000,000 program to provide aid for needy children in Germany.

Similar agreements are under discussion between Fund representatives and the commanders of the British and Soviet zones of Germany.

Under the Fund's program, more than $400,000 worth of cod-liver oil is now being distributed throughout Germany, including Berlin. Part of the current allocation will be used for the procurement of $250,000 worth of wool for processing by German manufacturers into finished clothing for some 250,000 children. Another $250,000 will be utilized for the procurement of leather and other materials for the manufacture of shoes for about 200,000 children.

In keeping with the Fund's policy, aid is given on the basis of need without discrimination because of race, creed, nationality, or political belief. UNICEF officials say that supplies shipped to Germany have moved freely into all four occupation zones.

Children on 20-Hour Day in Alaska Fish Cannery

Employment of children for as long as 19 and 20 hours a day and up to 87½ hours a week in an Alaska salmon cannery is one of the conditions found during the course of inspections for compliance with the child-labor provisions of Federal labor laws reported recently by wage-and-hour inspectors. Two of the children were only 13 years of age when hired.

This inspection disclosed that the cannery had employed eight boys and girls under 16 years of age. The inspectors reported that one of these worked as long as 19 hours a day and up to 87 hours a week during the peak of the canning season. Another worked as long as 19½ hours a day and up to 87½ hours a week. A third worked as long as 20 hours a day and up to 82½ hours a week.

Out of 47 establishments found in violation of the Fair Labor Standards Act or the Walsh-Healey Public Contracts Act, 12 of them, including 8 canneries, were violating child-labor provisions by employing 28 minors.

Eleven of the establishments, employing 20 children, have already agreed to come into full compliance with child-labor laws, according to the Wage and Hour and Public Contracts Divisions, United States Department of Labor, which directed the investigations.

Eighteen of the children were under 16 years of age (five of them only 12 years old), and one was 13. Two of the 12-year-olds were employed in hazardous lumbering operations; the other three were shrimp and crab pickers. A 16-year-old boy was working as a truck driver; another 16-year-old worker was employed in a sawmill.

University Offers Training for Institution Personnel

Beginning September 26, a special one-semester graduate course to train personnel for institutional care of problem children will be offered by New York University, with a grant from the Lavanburg Corner House. A number of fellowships are available. Inquiries should be addressed to the Graduate Division of Public Service, New York University, New York City.

To Train Psychiatrists for Child-Guidance Clinics

The American Association of Psychiatric Clinics for Children offers fellowships for training in child-guidance clinic psychiatry. These fellowships are made possible financially by the United States Public Health Service and sometimes by local funds. In addition, a few communities are offering to finance the training of psychiatrists who will engage to work for them for a given period following their training on a contractual basis. The training is for positions in community clinics where psychiatrists, psychologists, social workers, and others collaborate in the treatment of children suffering from emotional illness.

Most of the fellowships are for 2 years; some for 1. The stipend is in the neighborhood of $3,000 for the first year and about $3,600 for the second. The awarding of the fellowship for the second year is always dependent upon the quality of the first year's work. Prerequisites are graduation from an approved medical school, a general internship, and 2 years of approved general psychiatry (and personal qualifications essential for such work).

Opportunity is provided for the fellow to develop his own skills in a well-organized out-patient service with the support of a carefully planned training program and adequate supervision. The training centers are selected on the basis of standards which have been established by the American Association of Psychiatric Clinics for Children, and the fellowships are awarded by a committee of this organization.

For further information write to Dr. A. Z. Barhash, Executive Assistant, the American Association of Psychiatric Clinics for Children, 1790 Broadway (Room 916), New York 19, N. Y.

Child-Labor-Research and Youth-Employment Program Now in Bureau of Labor Standards

Investigation of the working conditions of some 2 million boys and girls who are employed the year round (and of more than a million more who take jobs in the summer), as well as the fostering of better employment opportunities for these youngsters, is now the task of the U. S. Department of Labor's Bureau of Labor Standards.

For a third of a century this child-labor-research and youth-employment program was carried out by the Children's Bureau, while it was in the Department of Labor. With the transfer of the Children's Bureau to the Federal Security Agency in July 1946 the program was placed by the Secretary of Labor in the Bureau of Labor Standards. The present action returns this work to the Bureau of Labor Standards, after a period of 2 years in the Wage and Hour and Public Contracts Divisions, to which it was transferred in 1947 as a result of a Congressional appropriation measure. This brings together again in the Bureau of Labor Standards the broad program of research and development of standards in the child-labor and youth-employment field and the promotion of improved working conditions and employment opportunities for youth.

Responsibility for the enforcement of the child-labor provisions of the Fair Labor Standards Act remains in the Wage and Hour and Public Contracts Divisions.

In the expanded program of the Bureau of Labor Standards are included not only research and promotion but also the continued negotiation and servicing of Federal-State agreements, whereby State employment and age certificates are accepted as proof of age for the purposes of the Fair Labor Standards Act. The purpose of these agreements is to prevent duplication and provide mutual assistance between State and Federal agencies in the administration of child-labor standards. (Nearly all the States have made such agreements with the Department of Labor.)

The Bureau of Labor Standards continues to investigate occupations to find which are hazardous for young workers, and, under the authority of the Fair Labor Standards Act, will continue to draft orders for issuance by the Secretary of Labor, prohibiting employment of boys and girls who are not yet 18 years of age in occupations found to be hazardous for workers under that age.

Teen-Agers State Their Case

What kind of parents do boys and girls want? Teen-agers in the Seattle (Wash.) public schools have their own ideas about this, and have prepared a statement on the subject, calling it "When Parents Fill These Basic Needs, Delinquency Hasn't a Chance."

These ideas seem to hold suggestions not only for parents, but for many types of workers in the children's field who need to gain and hold the respect and confidence of youngsters. Therefore we are publishing the statement here.

Love

"Home is where people love each other. We want to be sure our parents will love us no matter what happens. And it's so much better if Mother's there when we get home from school and if Dad gets home on time so we can all have dinner together, tell what we've been doing and play and sing awhile afterwards."

Understanding

"We want parents we can take our troubles to and be sure they'll understand. Some parents won't listen or let their children explain. They should try to see things a little more from our point of view. The way the world is today is just as hard on us as it is on them."

Trust

"Our parents could trust us more than they often do. They should tell us what we need to know about dating without being old-fashioned. Then they should put us on our own and expect the best of us so we have something to live up to."

Joint planning

"We want parents who realize we're growing up and stand beside us, not over us, the kind who are ready to talk things over instead of trying to boss us. We do want the benefit of their guidance in important matters, but we don't want to be nagged about every little thing. What we hate most is being dictated to. After all, this is a democracy!"

Respect

"We want our parents to respect us and treat us like teen-age people, not children. It is fine when they say, 'You're old enough to decide for yourselves' and even ask our advice on family problems. Then we really feel like persons. Of course, we want to respect our parents, too, and be really proud of them."

Privacy

"We want parents who are interested in what we're doing but not 'nosey,' who don't listen in on the phone or look through our letters or personal effects. We need a room to retreat to when things get too thick; a place for our own junk and hobbies, for pounding and painting. A real rumpus room helps."

Responsibility

"We want to do our share of family tasks and duties, but why can't we talk over who is to do what and why? Then it's more interesting and we can feel home is really ours, too. But we do need free time to get our home work done, and to join in activities that help our country."

Friendships

"Parents should understand we need both boy friends and girl friends, let us choose them for ourselves, and make them all feel welcome at our house. Of course we want Dad and Mom to know our friends and be in the house when they're there, but not hang around all the time. We want to have some fun just in our own way. Then we feel like staying home more."

Religion

"It's good to feel our parents have a religion they're sincerely trying to live, right in the family and everywhere else. It is really nice to have grace at meals and for the whole family to go to church. It makes us feel we really belong and gives us something to build on."

Illustrations:
Cover, Esther Bubley for Children's Bureau.
Page 18, Federal Works Agency.
Page 19, Soil Conservation Service, U. S. Department of Agriculture.
Page 21, courtesy of Play Schools Association, New York City.
Page 26, Frank S. Warren for Territorial Board of Health, Honolulu, Hawaii.
Page 27, Public Health Service, Federal Security Agency.

• FOR YOUR BOOKSHELF

THE CHILD'S FIRST DAYS IN NURSERY SCHOOL, a pamphlet for nursery staff; HOW A CHILD FEELS ABOUT ENTERING A NURSERY CENTER and WHAT NURSERY SCHOOL IS LIKE, two pamphlets for parents. New York Committee on Mental Hygiene, of the State Charities Aid Association, 105 East Twenty-second Street, New York 10. Single copies, 15 cents. Quantity discount: On orders $10 or over, 10 percent; $50 or over, 20 percent; $100 or over, 30 percent. 1948.

Once more the New York Committee on Mental Hygiene has tackled a problem that besets parents and has produced a series of readable and helpful pamphlets.

The two booklets for parents are excellent in showing what a nursery school can do for a child and what will happen to the child while he is there. The tips to a parent in How a Child Feels About Entering a Nursery Center should relieve the nursery-school teacher of some of the burden that ordinarily falls on her.

The pamphlet written for the nursery staff is well worth reading by pediatricians who are anxious to know what happens to children whom they send to nursery school. It will also give readers some idea of the use of the nursery school as a tool.

All three of the books, however, assume that with only a few exceptions all children belong in nursery school. It does not suggest that parents under normal circumstances can bring up a child quite adequately without the use of the nursery school. It seems to me that this factor should have been considered in the first pamphlet.

Henry H. Work, M. D.

POSTURE AND NURSING, by Jessie L. Stevenson, R. N., P. T. Published and distributed by the Joint Orthopedic Nursing Advisory Service of the National Organization for Public Health Nursing and the National League of Nursing Education, 1790 Broadway, New York 19, N. Y. Second edition, revised 1948. 96 pp. 50 cents.

The revised edition of "Posture and Nursing" has given this pamphlet added value to nurses. More illustrations have been added; these are clear and are well-directed toward the principles and activities presented in the text.

Emphasis is placed throughout on effective body mechanics in all nursing activities. These activities relate both to the actual care and instructions given patients with various needs and to the nurses' own body mechanics while performing these services.

This pamphlet should prove valuable both to hospital and public-health nurses. It should improve their own skill, and help them in instructing others.

Florence L. Phenix, R. N.

SOCIAL WORK YEAR BOOK 1949; a description of organized activities in social work and in related fields. Edited by Margaret B. Hodges. Russell Sage Foundation, New York, 1949. 714 pp. $4.50.

The tenth issue of the Social Work Year Book, announced as the last of the series published by the Russell Sage Foundation every other year for 20 years—except in 1931—maintains in 1949 the high level of usefulness set by the first edition, in 1929.

The 1949 Year Book in general follows the pattern of the previous nine volumes but of course has some changes.

Two of the three new topical articles concern the field of work with children. One of these, Homemaker Service, is directly related to the well-being of children, and State-wide Organization of Social Work not only describes the social and health services for children that are organized on a State basis but answers some of the questions now being frequently asked—such as which States have official commissions for children and youth, and which have voluntary State-wide organizations to consider problems in the child-welfare field.

Eleven articles have new titles in the current edition, and nine of these are on or contain material regarding work for children and youth. They are: Boys' and Girls' Work (dealing with leisure-time services provided for elementary and high-school-age boys and girls in groups); Community Organization for Social Welfare; The Crippled; International Governmental Social Work; International Voluntary Social Work; Parent Education: Public Relations in Social Work; School Health Services; and School Social Services. One of the three topics discussed in early issues and restored in 1949 under different titles is Protective Services for Children (present title).

A section on international agencies has been added to the Directories of Agencies. It lists 21 international agencies, public and private, that operate in the broad field of health and welfare, many serving children.

The many users of this concise encyclopedia describing organized activities in social work and fields related to it (including public-health work) must be relieved to learn from recent announcements that the Social Work Year Book is to be continued. In the future it will be issued by the American Association of Social Workers.

THE CREATIVE NURSERY CENTER; a unified service to children and parents, by Winifred Y. Allen and Doris Campbell. Family Service Association of America, 122 East Twenty-second Street, New York 10, N. Y., 1948. 171 pp. $2.75.

This comprehensive book discusses the basic philosophy of group programs for young children and emphasizes the fact that such programs have both an educational role and a family focus. The practices described have been developed primarily in day-care programs under social-welfare auspices. The authors believe, however, that many of these practices, and much of the philosophy, are applicable to all nursery centers.

The chapter on development of the child through group experience points out that at every moment of the day children are growing in every area of their development, as whole human beings. The right kind of group program helps them to experience the satisfactions of independence, of taking responsibility, of experimenting with materials and people, and of creative expression. It helps them also to establish warm and affectionate relationships with adults and other children.

In discussing the nursery staff as a team, the authors state that the various staff members should be at similar levels of professional competence. And they emphasize that when a staff includes several professional skills the director must be sympathetic to all. Case-work service, they say, should not be limited to "intake," since it has an equally valuable contribution to make to the continuing program.

The book closes with a chapter on adequate financial support. It recognizes that this support will come only when sufficient numbers of people are convinced of the worth of these group programs.

"The Creative Nursery Center" is a valuable contribution to the literature in the nursery-school field. It should be useful both to staff of nursery centers and to members of the board; also to the many citizen groups actively working toward increased facilities for the group care of young children.

I. Evelyn Smith

A limited quantity of each of the following reprints from *The Child* is available from the Children's Bureau:

Teamwork in Texas, by Katherine Glover. May 1949.

The Right Start; early foundations for job satisfaction, by Gertrude Folks Zimand. May 1949.

There Is Always More To Learn About Children, by Otto A. Faust, M. D. May 1949.

Ten Years' Progress in State Protection of Child Workers, by Lucy Manning. April 1949.

For the World's Children, by Ruth Crawford. April 1949.

To Combat Cerebral Palsy, by Donald J. Bourg, M. D. April 1949.

Child Care and World Peace, by Weston La Barre. April 1949.

Memphis Attacks Its Rheumatic-Fever Problem, by James G. Hughes, M. D. March 1949.

Baltimore's Temporary Group Home Helps Troubled Children, by Dorothy C. Melby. March 1949.

Workshops of Wonder, by Katherine Glover. February 1949.

Finland Builds Health Houses, by Paavo Kuusisto, M. D. January 1949.

Doctor Should Be Mother's Guide, Philosopher, and Friend, by Marjorie F. Murray, M. D. February 1949.

So That Children May Enjoy Better Meals, by Felisa J. Bracken and Jane Hartman. February 1949.

Fluoride Technique Demonstrated in Radio Program. January 1949.

Toll of Rheumatic Fever. December 1948.

What Are the Trends in Child-Guidance Clinics, by J. Franklin Robinson, M. D. December 1948.

Attitudes Toward Minority Groups, by Annie Lee Davis. December 1948.

• CALENDAR

Sept. 6–10—American Psychological Association. Annual meeting. Denver, Colo.

Sept. 12–16—Thirty-first National Recreation Congress. New Orleans, La.

Sept. 26–29—American Hospital Association. Cleveland, Ohio.

Sept. 26–30—National Conference of Juvenile Agencies. Forty-sixth annual meeting. Milwaukee, Wis.

Oct. 10–14—American Dietetic Association. Annual meeting. Denver, Colo.

Oct. 17–20—National League to Promote School Attendance. Thirty-fifth annual convention. New York, N. Y.

BACK TO SCHOOL—1949

All of us can see the mounting evidence that more young people are having difficulty in getting jobs than in any recent year—both boys and girls who have left school and those who want vacation work.

The war-boom days are over for young people in the labor market. Competition for jobs and for advancement places a new premium on education and on personal qualifications. "Back to School" is a slogan that is as greatly needed now as it was a few years ago, when jobs were begging for workers.

Hundreds of thousands of veterans of World War II, with college training, are providing stiff competition for young high-school graduates, as both groups apply for the lessening number of job openings. All these young people have their employment problems.

But what about the vocational prospects of the large number of our boys and girls who are now dropping out of school without completing a secondary education? (Only about half the children who reach the fifth grade finish high school.) These young people are even less well-equipped for making their way in the labor market than are the high-school graduates; and proportionately more of the boys and girls without a high-school diploma who want work are unemployed.

We cannot explain away the seriousness of national unemployment figures by saying that most of the increase in unemployment is among the June graduates. Unemployment among young people is a serious social problem. Its seriousness is not lessened by the fact that the individuals affected are young, or that they are recent comers into the labor market, or that they do not have to support families. It is true that the unemployment of these boys and girls may be less of an economic indicator than unemployment of their parents would be. But the difficulties of unemployed young people should be the concern of the community; and the way the community reacts to their joblessness is an indication both of its conscience and of its ability to build a generation better-equipped than the previous one. Is your community one of the forward-looking communities that want their young people to become citizens who can advance from a first job to better jobs; who can successfully assume family responsibilities; who will have a variety of interests so that their leisure will be filled with activities that will give them the greatest amount of real enjoyment; and who can take an intelligent part in the civic activities that make up a democratic nation?

In these modern times it becomes more and more evident that the road to good jobs and to a happy, well-balanced life lies through education and training. Let us then lend every encouragement to our teen-agers to return to school. And let us help them to surmount any obstacles that stand in the way of their schooling. For boys and girls who need financial aid, we must work out arrangements for student loans, scholarship funds, or some supplementary family income. And for the sake of all our young people, the valiant efforts that are being made in many parts of the United States to enrich school programs so that they will serve the needs and interests of every child must be pushed forward.

The scarcer the employment opportunities are, the greater is the always existing necessity for education, training, and a balanced personality if a boy or girl is to compete in the labor market successfully. For most of the boys and girls who are finding it difficult to get a job that will start them in the direction of vocational satisfaction, their best investment is to go back to school.

Elizabeth S. Johnson

Chief, Division of Child Labor and Youth Employment, Bureau of Labor Standards, U. S. Department of Labor.

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Managing Editor Sarah L. Doran
Art Editor Philip Bonn

FEDERAL SECURITY AGENCY
Oscar R. Ewing, Administrator

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Arthur J. Altmeyer, Commissioner

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Katharine F. Lenroot, Chief

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the CHILD

PRENATAL CLINIC SHOULD OFFER MEDICAL SOCIAL SERVICES

ELIZABETH P. RICE, *Assistant Professor of Medical Social Work, Department of Maternal and Child Health, Harvard School of Public Health, Harvard University, Boston*

IN ANY PROGRAM whose purpose is to promote maternal and child health, it is essential that the workers understand the importance of social, economic, and emotional factors in the lives of mother and child. If we recognize these factors in a mother's life during her pregnancy, and try to fulfill her needs, we may contribute greatly not only to her own well-being, but also to the child's chances of starting life with those securities and satisfactions that will help him to become a well-adjusted adult.

Social factors affect prenatal care

First of all, social or environmental difficulties may even prevent a mother from obtaining adequate medical care during her pregnancy.

If, for example, she lives in an isolated place, or a place far away from any doctor, she is likely to be cut off from medical services. Again, the cost of medical care may prevent a mother from getting adequate obstetric supervision; this is likely to happen when a mother lives in a place where clinic services are scarce.

Or psychological influences may prevent her from obtaining prenatal care. In this country we have many different cultures, some of which conflict with programs for medical care; and the attitudes of relatives and friends, or the accumulation of folklore and superstition, may prevent a woman from seeking care in pregnancy, or from carrying out medical advice.

Then, too often the procedures at the prenatal clinic are not conducive to encouraging mothers to come for care. Long waiting periods, lack of privacy, and the attitude of the personnel may discourage a mother from making regular visits to the clinic. Instructions are often given ineffectively, and many mothers do not really understand the need for the periodic visits.

Since the baby's early life revolves around his mother, her ability to give him the affection he needs may determine to a large degree the adjustment that he makes later in life.

Some mothers will not be able to obtain the recommended diet. This may be due to the cost of the foods, but more often it is due either to the mother's own lack of understanding of the importance of the diet or to her inability to plan for it and to prepare it. The dietary habits of the mother before her pregnancy will markedly affect her willingness to make the recommended modifications. Her food habits, as well as those of her family, will, of course, be affected by cultural patterns.

Besides medical care during the prenatal period, many mothers will need help in planning for the care of their families during the approaching con-

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Given at the seventy-sixth annual meeting of the American Public Health Association, at Boston, Mass.

finement. Sometimes a mother is unable to find anyone to remain with her family while she is in the hospital. If she is new in the community in which she lives, she may be far away from relatives and friends, and she may be unable to enlist the interest of new neighbors. Often a mother will come to the time of delivery with inadequate plans made for her children.

To meet this situation, in some communities a social agency—public or private—will provide a well-trained homemaker who will assist the family during the mother's absence, caring for the children and helping with the housekeeping.

Emotional problems most important

Important as are many of these environmental factors, even more important are some of the emotional problems. We now believe that the attitude of the mother and father toward the coming baby largely determines whether or not the baby has a good start in life. This is especially true of the attitude of the mother. We are concerned, therefore, that the early emotional relationships between mother and child be fostered. Fortunately, many mothers are eager to have their babies and are ready emotionally to give them the care and affection they need.

Some mothers, however, have not planned to have a child, and pregnancy may interfere with their hope of continuing their education or their employment.

Some are not yet ready emotionally to assume the role of motherhood, and they feel that the ensuing responsibilities and restrictions are greater than the pleasures.

Some wish the baby had not come so soon; others admit, with feelings of guilt, that they do not want a baby at any time. Such mothers frequently reveal their feelings in their rejection of the child, but they tend to justify their lack of enthusiasm by such explanations as their need to continue working or their fear that they may lose their husband's affection.

Many mothers fear the pain of the delivery itself, or doubt that the child will be normal, physically or mentally.

Many mothers are concerned because this child is coming so close to the previous one, or because they already have more children than they can care for adequately.

In every prenatal clinic there are so many mothers who need help with their social and emotional problems that medical social services would seem to be essential for complete care.

Mother's anxiety affects child later

These anxious mothers tend to be oversolicitous of themselves during pregnancy and to worry about their babies. And anxieties of this kind may later prevent the mother from giving her child the affection that he needs if he is to feel happy and secure. A mother needs an opportunity to express her feelings to an understanding person, for such unburdening of her mind may help her to realize how her anxieties may affect herself and her child, and this realization may have a favorable influence on her attitude.

Since the baby's early months revolve around the mother, her ability to give him the affection he needs may determine to a large degree the adjustment that the child makes later in life.

A baby who is separated after birth from his mother, or from a person consistently substituting for the mother and providing motherly care (such as those who are placed in institutions or are frequently shifted from one person to another), is a sad contrast in his social and emotional development to a baby who has a loving mother or a motherly substitute. It is obvious that the kind of person who cares for the child is even more important to the well-rounded development of the child than the physical conditions of the home. Indeed, a social agency sometimes decides that a certain child should remain with his own mother, who loves him, even though the physical condition of the home may not be of the best.

Child-welfare workers aim to provide the best substitute care for the child who cannot stay with his own mother for one reason or another; and they are faced with the difficult problem of finding for each child foster parents who have sufficient capacity to give the child both the physical and the emotional satisfactions he needs.

Special plans for child born out of wedlock

Some mothers, during their prenatal period, will be uncertain about their plans for the coming child—whether to keep him or not. This is especially true of a woman who is not married or of a married woman whose child is not her husband's. This decision is a serious one for the mother to make, and during

(Continued on page 16)

HELPING NEGLECTFUL PARENTS TO BECOME RESPONSIBLE

BARBARA SMITH, Case Supervisor, Protective Services, Baltimore City Department of Public Welfare

WHEN children are so neglected by their parents that the community must take notice of that neglect, what should be done? Should the community, recognizing a duty to safeguard children from dangers they cannot protect themselves from, take children away from their neglectful parents? Or should the community, realizing how much every child needs his parents, try to root out the neglect while keeping children and parents together?

Parental neglect shows up in children in many ways. The evidence is not always in outward signs or in the child's physical appearance; some children show neglect in less direct ways—by being just too good, by withdrawing into themselves, by stealing, by playing truant from school, by getting into fights all the time, by engaging in sex activities.

The community's right and duty, embodied in the law and in the courts, to protect children—even from their own parents when their parents endanger them—is often carried out through the protective service of a public or private social agency. So these agencies are faced with the problem of deciding how to help neglected children. And it is a hard problem to solve, requiring a specifically qualified staff. From my experience in the protective services of the Baltimore Department of Public Welfare, I am convinced that, while it is absolutely necessary for some neglected children to be placed away from their own homes, most of them should remain, and can remain, with their parents. But in staying they should be protected by the agency's efforts to help the parents change from neglectful fathers and mothers to loving ones.

Perhaps I should say for readers unfamiliar with the field of social casework that protective service may be offered in three ways: It may be offered by agencies established specially for this work and doing it solely; by agencies that do various types of work for children and have a unit for protective services, separate from such other services as foster care (it is so in the Baltimore Department of Public Welfare); and by generalized family or child-welfare agencies in connection with other services they give.

The trend is toward making the protective service of a community distinct and specialized in order to emphasize to the parents who are referred to it one of its main differences from other casework services. This difference is that in protective services the relations of parents to the agency are not entirely voluntary. For the well-being of the children served, the parents are not free to refuse service or to end prematurely the agency's work on behalf of their sons and daughters. The agency decides when the parents are ready to assume full responsibility.

It is necessary that some children be placed away from their own homes, for there are family situations that no amount of case-work skill can change. There are limitations beyond remedy in some human beings who are parents. I think of a family of fatherless children whose mother is an imbecile. Some parents are so seriously alcoholic that for safety their children have to be taken from the home until the parents are better. Sometimes, for other reasons as well, it is too dangerous for children to stay in their home for another night. These situations requiring immediate action are perhaps the hardest ones for a protective worker to face. No matter how thoroughly convinced she may be about the rightness of having a child taken away from the extreme hazard in his home, when the actual separation of parents and child comes it is exceedingly hard to live through. But the children themselves often come to the rescue.

I shall never forget one such rescue when a 9-year-old girl put her arms around her alcoholic mother and said, "Don't cry, mother, don't cry. It doesn't have to be forever, you know. It's just till daddy and you get well and get a nice place, because you know we can't live like this." That youngster expected the community to come to her aid and trusted it to see her through. To find a temporary home for her and her brothers and sisters was right.

Children need their parents

When I say that most neglected children should remain at home, I don't for a minute mean that they should continue to be neglected. The agency has to be convinced that their parents not only want to make life different for their children but can actually begin to change the conditions of neglect, whatever they are.

With agency and parents working together on this, parents can usually find the way back to the affection of children they had forgotten how to love or have never let themselves love. The new affectionate understanding between them, as it begins and as it grows, changes a child outwardly; haircuts, clean clothes, clean, healthy bodies, make them look cared for. But much more important is the difference in attitude toward home and school of the children who are now loved. How different from the look of tension or of withdrawal is the relaxed look that replaces it when the child feels secure in the soundness of his home and feels wanted and loved by his parents.

I have used expressions that sound very simple—"secure," "wanted," "loved." Perhaps it seems as if I were unaware of how hard it is to bring about the reality behind these phrases, as if I thought that parents and children could achieve these interrelations with small

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Given at the seventy-sixth annual meeting of the National Conference of Social Work, at Cleveland, Ohio.

effort. On the contrary, I know it is no easy task, but I believe that the very difficulty of it can be turned to good use, and the facing together by parents and worker of how hard it is to be, can be made the point of beginning.

The agency that gives service to neglected children and wants to test whether they can remain at home has to look very realistically at the problem to be solved while the children stay there. Keeping them at home involves risks; criticism may come from many sources; support for such a venture may be lacking. With all three possibilities the agency has to come to terms and decide whether it has the experience and conviction necessary to enable it to give the worker strong enough support in her work with the parents.

How an agency begins

As the Baltimore Department of Public Welfare became more and more convinced that it was extremely difficult to help neglectful parents, it was able to work out a procedure for this special work that has proved valuable.

First, because something in the situation has to change, yet human beings are reluctant to make the effort needed for a change, it seemed best to set a time limit within which convincing evidence of change should appear. This time limit seemed necessary to get things going toward the goal of better family life. Six months seemed a reasonable time in which to test whether parents can better their care of their children, and that period of trial was set up.

Secondly, because we believe that the way relations begin is important, we decided to develop some special procedure for use when parents first came for an interview. Together we needed a way for them to give their decision that, after considering the possibilities, they want to try to keep their children with them by learning to care for them. The agency worked out an application form that parents sign and that plays a big part in their getting started. The signed application gives the worker and the parent something definite to hold to as they begin to work together.

I recently took part in a discussion about how a worker begins with a mother who is neglecting her children and who lays the blame for their difficulties elsewhere—on the school, on neighbors, or on relatives. One worker suggested that the way to begin was to be "accepting of the parent," that is, to let her see that you are looking at the situation without judging any act or without blaming any person, wanting only to understand the facts and the feeling behind the facts. She would begin by asking, "And how does all this affect you?" focusing the attention on the parent. Another worker said that you should first "isolate the problem," focusing on the problem rather than the person.

It seems to me more realistic to begin by looking at the actual, pressing situation. The children are being neglected: why are they being neglected and can their home life be made any different? If parents claim that nothing is wrong with the care they give their children, that the accusations are all false, then they have to be held to clearing themselves. If they have been through a court action, they can appeal the decision against them; if they have been referred to a protective service by another type of social agency or by another division of the same agency, they can go back and fight to have this referral changed as incorrect or unjust. Unless parents take such action, the worker can begin by accepting the rightness of the referral.

If the parents say they want to work with the protective service to keep their children, the worker has no reason to trust them just on that statement. They have to earn this trust and the agency has to help the worker with the risks involved.

The service says to the parents: We shall need to know that the children are in school and that they are well. You will have to bring written medical and school reports. And we shall need to know about the home conditions; if they are bad, what are you doing to change them? To watch this the worker makes monthly home visits. But we know that more important than a cleaned-up house or satisfactory medical and school reports is the change in feeling and attitude that has to take place.

This significant change comes about only as parents let themselves enter into a relation with the worker, risking the possibility of being hurt. They have to trust her enough to take help. Under these exacting circumstances, the contacts cannot be carried on through casual appointments; we set up a schedule of weekly office appointments, strictly held to.

This is asking a great deal from parents. Is it worth while to them? Do they want to keep their children enough to work with a service that demands so much of them? I started out in this protective service very hesitantly, but I soon found that even the most battered, discouraged parent can find a tremendous amount of strength and will to carry through on every requirement if he wants to keep his child. In the doing of practical things such as going to see the school teacher and the doctor or keeping the weekly appointment, the parent (and the worker) will soon find out whether the parent has in him the possibility of becoming a trusted and responsible mother or father.

Testing is continuous

I don't want to give the impression that the signing of the application assures clear sailing ahead. There are resentful, defensive persons who feel guilty about what they have done, yet are afraid to acknowledge guilt even to themselves lest all their defenses crumble. They have been hurt too often to risk trusting anyone quickly. While they are showing in a hundred ways how much they want to be accepted as trustworthy, they will fight with every weapon they have to keep a wall between themselves and the worker.

The worker understands their resistance and appreciates the strength it indicates, but she can let it go on for only so long. She is responsible for knowing how the children are getting along; she is expecting the parents to provide her with this information. If parents are so busy fighting the worker and her requirements, if each parent is so preoccupied with his feeling against the other parent, or if they are so lost in their own woes that they cannot see what is happening to their children, the worker has to question whether the service should go on. Is it time to consider other plans for their children? All along the way this kind of evaluation and testing goes on, with the fathers and mothers free to choose whether or not they will meet the requirements.

So deeply hurt

One aspect of this service demands unusual skill on the part of the worker. It is when the parents decide to try to improve, but the child they have neglected is not willing to stop being neglected. That may sound strange, but neglected children, just like their parents, have to learn to trust people again. They cannot easily forgive what has happened. Why should they?

I remember two girls in different families who fought to keep their position as neglected children. Each had the sympathy of neighbors, school teachers, and classmates. One, a teen-ager, continued to tell at school alarming stories about her mother's treatment of her until her mother went directly to the school to set matters straight. The other girl, younger, had worn a bandanna over her head to conceal nits in her hair and sores in her scalp from this neglect. After her scalp healed and her hair was attractive again as a result of treatment she would wait until she got outside her home and put on the old bandanna so that no one could see the improvement.

The value of frankness

This is just one kind of problem that parents have to learn to handle. No wonder a worker cannot promise mothers and fathers that it will be easy. But she can promise them one thing, and to me this assurance is a requisite of all protective work. She can promise parents that she will not hold back her feeling from them—that she will try at all times to let them know where they stand with her. These parents will sometimes say of a worker, "She always told me the truth, hard as it was for me to take." That frankness they can respect, and it gives them the confidence in others they so badly need to have.

We have digressed somewhat from the question how the worker begins to talk to parents who have hurt their children deeply—as deeply, for example, as did the two mothers whose daughters wanted to seem to be still neglected. We tend to think that to help these parents workers must discipline themselves, but that is a misconception if discipline is taken to mean that we muffle our feeling. It is unrealistic to suppose that we can look at a neglected child and not feel angry. Letting the parents sense our anger can be helpful if we let him sense also our conviction that things can change. The parents realize we are saying, "This is awfully bad. You have hurt your child deeply but we think you will not keep on hurting him: you can change if you really want to change." Sensing this is often the force that keeps parents moving forward through many difficult days of trying to be different.

Parents test the worker

Having discussed the problems that parents and caseworker face together, I should like to mention also some problems the caseworker in protective service has.

First of all she has to acquire a proper appreciation of the authority she represents: that is, the right and duty of the community to protect defenseless children from harm. She must feel confident in herself when she uses that authority. She has to keep her attention focused always on the children and their care, at the same time strengthening her relations with the parents. She has to stand up to tests the parents put her through, knowing that this testing can be their way of moving toward her, of becoming ready to work with her for their children's well-being.

Sometimes distrustful parents, knowing that the focus is on their children's welfare, are only too ready to make this focus an excuse for holding themselves aloof from the worker and the service. But they don't always succeed in doing so because they don't really want to. Nothing is quite so exciting to the worker as seeing the delighted look on the faces of parents when they realize that they have been drawn into the work for their children—that they cannot stay aloof from it.

I remember vividly the mother who tried to catch me up on this primary concern for the child. I had felt that she was keeping back a lot of her feeling as we talked together about her son, Paul. Paul always used every chance to stay home from school, and his mother and I had worked hard on this. On one particular day she told me she was out of funds. She had food enough at home but she was waiting for her application for aid to dependent children to go through; that is, for her application to be accepted and for the allowance to begin. We had been talking about Paul's need to look like other children at school, which led her to say that the boy needed a haircut badly. Before she left she asked me for a loan for the haircut.

How does a worker know this request is a test? Perhaps it is by the intense, waiting look that suddenly comes into the mother's face. I doubt if I realized the issues; I just knew this mother was taking a chance with our relations as joint workers for Paul, and was trying to find out if I considered Paul's haircut more important than what she and I had experienced together. I mumbled some kind of awkward refusal, saying I thought Paul could wait a day or two for a haircut if he knew the situation; or he could earn money for it doing errands. I didn't count on this test being the decisive factor, the turning point for this mother. Had I given her the small amount for the haircut I would have put her on a different level from mine—we would no longer have been coworkers for Paul.

The next time the mother came in she was a different person. When I referred to the loan and how badly I felt about refusing it, she grinned with all the mischief in the world in her eyes and told me how she had borrowed clippers and turned barber, and how Paul was "real proud" of the results. From then on this woman and I knew that we had a relation with one another that could take many knocks and not be destroyed.

Mother and worker join hands

This mother and her little boy did have something in common when they came to the service. But at first she acted more like a big sister than a parent, not knowing how to be a mother. As we worked together on what it means to be a parent—the satisfactions as well as the responsibilities—she began to develop new and better relations with her son. But, as I said earlier, most of the parents and children have nothing in common. In beginning with them the worker has to keep herself from becoming close to the children in a way that leaves their mothers and fathers in the background.

It would be easy to take over for a

(*Continued on page 45*)

FOR BETTER MENTAL HEALTH

HENRY H. WORK, M. D., *Director, Mental Health Unit, Children's Bureau*

THE MEN AND WOMEN who took part in planning for the National Mental Health Act, which was passed in 1946, recognized early that most people's emotional difficulties develop from beginnings in childhood, and that efforts toward improving the mental health of children are likely to be more fruitful than the same amount of effort expended on helping adults. This recognition has also been evident in the administration of the act by the Public Health Service of the Federal Security Agency. All this is very encouraging to those who feel that a broad program for the health of children includes fulfilling the child's mental-health needs as well as his physical ones.

The grants in aid under the act are for three purposes: (1) Research relating to the cause, diagnosis, prevention, and treatment of psychiatric disorders; (2) training of mental-health personnel; and (3) establishment and expansion of community mental-health services.

The main part of the work under the act is done by the States, and by universities, laboratories, and other public and private institutions, and by qualified individuals. The Public Health Service is authorized, however, to carry on some research—through its new National Institute of Mental Health, created by the act—and to carry out demonstration projects or field studies. (One of these projects, the Prince Georges County Mental Health Clinic, will be described in a forthcoming issue of *The Child.*)

Parent-child relationships are the subject of study in a number of the research projects now being carried out with the help of funds granted under the National Mental Health Act.

Research is, of course, the basic structure on which all medical advance is founded, and the National Mental Health Act is definitely encouraging research. Medical schools, clinics, and other institutions dealing with the problems of disturbed personality are invited by the Public Health Service to submit their plans for research projects. The plans are reviewed by a research-study section, comprised of authorities in several disciplines, and are then turned over to the National Advisory Mental Health Council, which was created by the act to advise the Public Health Service on its mental-health work. And when the council has recommended a project, and it has been approved by the Surgeon General, the grant-in-aid is paid directly to the agency or individual that is planning the research.

Children's difficulties studied

As might be expected, there is a tremendous range in the types of problems submitted and in the methods planned for solving them. Of most importance to those of us who deal with children is the high percentage of the research projects chosen that deal with disorders peculiar to the younger age groups or that include basic studies into the genesis of the problems of adults, studies which in themselves usually force the investigator to turn to the difficulties of children.

For supplying trained workers

Many of the research studies that have been approved highlight the need for the trained mental-health workers that are essential if the purpose of the act is to be fulfilled; namely, "improvement of the mental health of the people of the United States." And the act recognizes this need by providing grants to nonprofit educational institutions, for training psychiatrists, clinical psychologists, psychiatric social workers, and psychiatric nurses. Persons eligible to receive such training deal directly with the university or other nonprofit educational institution offering the training.

Happy family life is a sign of mental health in both parents and children. Work under the National Mental Health Act helps to make it possible for more families to live together happily.

Mental-health workers are needed, not only to fulfill the needs of the new services projected but also to man the services previously existing.

Psychiatric services insufficient

Before the act was passed much of our specific awareness of the existing need for help with emotional difficulties grew out of wartime information collected concerning members of the armed forces. The great need for psychiatric services during the war was shown by the fact that the Army and Navy had used in a psychiatric capacity physicians who were not psychiatrists. And this in turn emphasized the extent of the civilian problems that the psychiatric services available to the general public were not solving.

The war also focused our attention on the fact that persons with severe psychotic disturbances, who had previously been considered the outstanding problem in mental health, are far less numerous than are persons in the neurotic group, whose emotional disturbances may be equally crippling. The man of the armed forces who needed psychiatric therapy constituted both a symbol of the community's wants and a challenge to the community to supply the help.

The training committee of the National Advisory Mental Health Council, which passes on the suitability of various medical schools and other educational institutions to prepare professional personnel for mental-health work, emphasizes training for persons who are in a position to train others, through teaching or supervision.

The time needed for the training is long, but it may be possible in all these fields to find persons who have completed some of their preliminary work and need only the final year. In all the professions concerned there are trainees who plan to work in the children's field, and this is being encouraged in most of the projects. The current standards of the American Board of Psychiatry and Neurology strongly recommend preventive work for children, and the curriculums for both psychologists and psychiatric social workers have long stressed such work.

As to the groups being trained, the programs planned for nurses doing community mental-hygiene work are the most experimental. Nurses may well prove to be valuable in bringing mental-health services to the community and in keeping patients interested and active in their treatment.

The largest amount of money authorized under the National Mental Health Act is the sum for grants-in-aid to the States to help them in establishing and improving mental-health services in their communities. In order to be eligible to receive this grant, the government of each State has designated one of its constituted departments as the State mental-health authority. In a few States this is a separate department of mental hygiene, which coordinates the variety of facilities needed to care for persons with emotional and personality problems. In most of the States, however, this authority has been vested in the department of health or of welfare, usually the department of health.

The money allocated for grants-in-aid to the States is given in the form of funds to be matched in the ratio of $2 for each $1 of State money used. The plans for the use of the money are as varied as the range of problems in the States and the availability of their existing facilities. Many States are extending their mental-hygiene clinics; some are subsidizing further training for their personnel; and clinics already functioning are being strengthened and their scope expanded. The lack of trained workers in the psychiatric fields is handicapping all the State programs and emphasizes the importance of the training provisions of the act. All but two States are now participating.

To fulfill broad purpose of act

All this work under the National Mental Health Act will be useful in improving the mental health of the people as a whole.

But a tremendous amount of work will have to be done before the persons who are closest to children, such as parents, teachers, and nurses, have the knowledge that they need about the causes and prevention of emotional disturbances—knowledge that will enable them to reduce such disturbances to a minimum in the children they deal with.

Let us hope that the research, training, and community-services work fostered by the act will help to fulfill the great needs of the people for more and more knowledge of the basic principles of mental health, so that children of the present and the coming generations may profit from all this work. The National Mental Health Act is making a bold and necessary start in this direction.

COORDINATED STATE PLANNING TO COMBAT POLIOMYELITIS

A Suggested Guide for Use by State Poliomyelitis Planning Committees

Prepared jointly by Federal Security Agency, Social Security Administration, Children's Bureau, and the National Foundation for Infantile Paralysis. New York City.

UNTIL MEDICAL SCIENCE learns more about the cause and prevention of poliomyelitis, epidemics of this disease must be expected and prepared for. Such preparation should be State-wide and requires the cooperation of professional individuals and groups, of the hospitals and other facilities that provide care, and of the officials and voluntary agencies responsible for making the care available to those who need it.

These forces are already working together in the fight against epidemic poliomyelitis. In the hope of promoting even closer teamwork, a national voluntary organization, the National Foundation for Infantile Paralysis, and an official Federal agency, the Children's Bureau of the Federal Security Agency, have joined in making the following suggestions for a cooperative attack on the disease.

If the care of patients with poliomyelitis is to be planned effectively, particularly when there is a great increase in the incidence of the disease, cooperation is necessary among agencies—State and local, public and private—that make poliomyelitis their direct concern. This cooperation can best be obtained through formation of a State committee.

The health officer in each State should be responsible for calling together the State committee, which might be known as the State polio planning committee. In addition to the State health officer and the director of the State crippled children's program, the committee might include representatives of:

The State child welfare agency.

The National Foundation for Infantile Paralysis.

The American National Red Cross.

The National Society for Crippled Children and Adults.

The State medical society.

The State nurses' association.

The State hospital association.

The State chapter of the American Physical Therapy Association.

The American Association of Medical Social Workers.

The committee may desire to expand so as to include representatives from other agencies.

This committee should develop a State plan to insure good and complete care for children and adults with poliomyelitis. Regardless of whether the poliomyelitis is sporadic, endemic, or epidemic, the committee should swing into action. It might serve as a clearinghouse for information regarding the interests and responsibilities of its component organizations. It would (in all probability) elect a chairman to lead discussions and assign tasks. Members having accepted assignments might work individually and report back to the committee.

To tackle specific problems, special subcommittees of key persons most able and informed in these problems could be appointed.

Examples of problems which the committee might consider and attempt to solve are:

1. Planning the program of care so as to maintain contacts between patient and family.
2. Increasing hospital bed capacity for acute, convalescent, and long-term cases.
3. Providing adequate equipment for hospitals.
4. Providing additional professional personnel for hospitals.
5. Providing adequate housing and maintenance for recruited personnel.
6. Providing competent supervision and in-service training for emergency personnel recruited for hospitals.
7. Providing continuity of total care from the acute period through convalescence and after-care.

The influence of the combined organizations in solving such problems can be expected to be greater and more effective than if individual organizations worked independently.

The polio planning committee would be the key group in the State because it is responsible for coordination of the functioning of State and local public and private agencies so as to effect a unified State-wide plan, and therefore it could help to coordinate the planning and activities of local polio committees. Such a plan would encompass the following activities, most of which are already functions of various agencies within the State:

A. Health Education

1. Provide information on polio for the public.
2. Provide information on polio for professional groups.

B. Hospital and Convalescent Care

1. Facilities.

a. Determine primary hospitals (polio centers) where all necessary services of high quality can be provided in accordance with State crippled children's services' hospital standards for care of crippled children; also determine secondary hospitals to take overflow until patients can be moved to a primary hospital. A certain number of beds available and plan for expansion and contraction in accordance with epidemic needs.

b. Encourage and assist general hospitals in development of policies and accommodations needed in order to accept polio patients.

c. Plan for early hospital discharge by providing all necessary treatment services for a patient in his own home, a convalescent home, or a foster home.

2. Standards.

a. Promote the application of good standards for selection of hospitals to provide care, and encourage and assist others to meet good standards.

b. Promote the application of good standards of care in convalescent homes and in children's own homes or foster homes.

3. Equipment.

Assess existing equipment and help in meeting additional requirements.

4. Housing.

Plan for adequate temporary housing for emergency personnel.

5. Transportation.

Plan for provision of transportation for patients, personnel, and parents.

6. General procedures.

a. Establish policies and procedures for authorization of hospitalization and admission of patients (in accordance with responsibility of party assuming the obligation) so as to assure immediate acceptance of all patients regardless of residence, economic status, or other factors.

b. Develop procedures for routing admission and discharge information and other necessary reports between hospitals and the State crippled children's agency and other agencies or individuals responsible for continuing care.

7. Payment for care and service.

Review methods and rates of payment for physicians and for hospital care and other medical-care services in an effort to arrive at uniform and adequate reimbursement for comparable services.

C. Personnel

1. Promote the application of established qualifications for professional personnel.

2. Develop plans for providing around each hospital center personnel adequately trained in the care of polio patients, by—

a. Ascertaining number and location of experienced personnel;

b. Estimating additional number and type of personnel needed for administration, supervision, and teaching in an emergency situation;

c. Providing for training of this group, prior to epidemic, within established center;

d. Developing plans for emergency courses for professional and nonprofessional personnel. This would include recruitment of teaching staff, organization of facilities, and production of outlines for instruction.

3a. Determine the number of professional and nonprofessional workers needed for a given number of cases in various settings and under various conditions, according to present estimated standards. For example:

(1) It is estimated that if the patients are severely involved the case load per physical therapist should not exceed 6 patients a day. If the patients are not severely involved the minimum should be 12 patients a day.

(2) The nursing load is comparable to that in a hospital with a communicable-disease pediatric service, with increase in the nurse-patient ratio when the nurse has responsibility for bulbar and respiratory cases.

(3) It is estimated that in convalescent units, at least two trained nonprofessional workers may be used to each professional nurse.

For giving hot packs, teams consisting of one professional nurse and two trained nonprofessional workers or trained volunteers have been found effective and economical.

(4) Resident physicians are to be recruited and assigned where needed.

3b. Promote the use and training of nonprofessional personnel and volunteers in convalescent care.

4. Establish a plan to assure supervision within their respective fields of local and emergency personnel, both professional and nonprofessional.

5. Review numbers and types of additional professional personnel to be recruited by State agencies, the American Red Cross, the American Physical Therapy Association, or the National Foundation for Infantile Paralysis, and plan for shifting emergency personnel to meet State-wide needs and for most effective distribution and use of regular personnel.

6. Plan for provision of teachers, recreation workers, and vocational counselors for children under long-time care.

7. Promote plan for the recruitment, orientation, and use of nonprofessional personnel.

8. Plan for adequate housing, maintenance, and social needs for recruited personnel.

D. Braces and Other Appliances

It is suggested that the committee plan for augmentation of the supply of braces and other appliances during an epidemic.

Serious delays in supplying braces and other appliances, owing to overloading of local brace shops on account of an epidemic, is a frequent cause of unnecessary delay in treatment and rehabilitation procedures. Such delays result in prolonged, unnecessary bed care and costly hospitalization.

The committee may—

a. Review adequacy of local brace-making facilities in the State;

b. Encourage local bracemakers to increase production to the limit of their facilities;

c. Where necessary promote the use of appliance-making facilities outside the epidemic area.

E. Diagnostic and Consultation Services

1. Plan for providing diagnosis and treatment consultation to local practitioners by qualified consultants.

2. Promote the application of standards for laboratory-diagnostic services.

3. Plan for staffing, equipping, and conducting additional diagnostic and treatment out-patient clinics, and holding existing clinics more frequently if necessary.

F. After-care

1. Require interagency routing of information between hospital and other local agencies or individuals responsible for continuing care, when an inter-State or intra-State area or agency is involved.

2. Plan for expanding and supplementing existing health facilities and services in order to meet medical, nursing, physical therapy, and medical social needs.

3. Plan for establishing and conducting additional clinics as long as necessary.

Reprints in about 4 weeks

HOW DOES FAMILY HISTORY AFFECT A CHILD'S CHANCES FOR ADOPTION?

AS WE learn more about control of disease, more about how children develop, and more about successful adoption, we know that certain children who used to be considered poor adoptive risks should be placed for adoption.

One may fill out that general statement with convincing details from the pages of a report issued by the Child Welfare League of America on a workshop held last spring on Adoption of Children With Pathology in Their Backgrounds. Fourteen agencies interested in adoption took part in this workshop session; members of four of the agencies submitted case material for discussion.

The workshop focused its discussion on the adoptability of children who have a history of disease in their families but none in themselves. The agency representatives agreed that bias and prejudice about such a history confuses people about the actual significance of these conditions to the children's potential development.

Some of the aspects examined by the workshop were: What should a child-placing agency do about a child whose immediate background or heredity is known to include a pathological condition that raises doubts about his potentialities for normal development and for normal family life? At what point in this process of determination can an agency, with conviction, present such a child for adoption, conveying its conviction to the prospective parents? How long does it take an agency to reach a decision on adoptability, bearing in mind the importance to the child of early adoption? What are the criteria for selecting appropriate homes for these children? What should the agency tell the prospective parents about the child and his situation?

These questions show that in planning for the adoption of these children added precautions must be taken and procedures followed that are somewhat different from the usual ones. This is to make sure that the child gives promise of normal development and a normal capacity to fit into family life.

The five case records on which the workshop based its discussion illustrated five conditions appearing in the children's family history only—but not in the child's own—that called for these special precautions, as well as additional medical tests before the child's placement was decided upon. These conditions were: (1) diabetes, which has long been controllable; (2) epilepsy, also controllable; (3) a communicable disease, syphilis; (4) a brief mental breakdown experienced by the child's mother; and (5) dwarfism associated with feeblemindedness.

For each child it was necessary to get a complete, responsible medical opinion, the best obtainable, to decide whether adoption is the best plan; and to decide what to tell the prospective parents about the child's background.

Members of the workshop agreed that there is enough medical knowledge about diabetes and epilepsy so that their presence in a member of a child's family does not necessarily make him unadoptable.

Medical opinion the criterion

For the last three conditions the agency must get complete and reliable medical reports; decision about adoption depends on the agency's ability to obtain medical opinion of this caliber.

To illustrate the case material presented for discussion—the heart of the report for the general reader—we summarize the histories of the five children. The suitability of this type of permanent placement is being scrutinized with special caution because of some factor in each of their family histories.

Frances has diabetes in her heredity

Frances was referred for adoption when she was 2 months old. The social history showed that her paternal grandmother had died of diabetes. Because of medical opinion that there is a greater tendency toward the development of diabetes in a child when the disease is found in the background, the pediatrician decided that Frances should not be placed for adoption immediately. She was therefore placed in a foster-family home for further study. The case record then gives the steps that were taken medically to determine whether Frances was free from diabetes. The medical decision was that there was no evidence of the disease.

History told in full

Frances was presented to prospective parents at the age of 10 months. The parents were told her medical background and history in full, as well as the results of the recent tests showing that she did not have diabetes. She was placed in the adoptive home and supervised there for 14 months. She was retested during this period; no signs of diabetes developed.

Frances was adopted at the age of 26 months. Her new parents have in writing all the medical information the agency obtained about her.

The condition in Frances' background, diabetes, caused no difficulty for the agency in giving the child's complete history nor for the parents in accepting her.

Sallie's mother was epileptic

Sallie was referred for adoption by a member of the staff of the State health department. The agency arranged to have her examined by an authority on epilepsy, and also given an electroencephalogram (a routine measure taken for children with epilepsy in their background). The child presented no problems other than her mother's history of epilepsy, and her mother was the only member of her family who had it. The mother had adjusted to school and work. She had been under medical care for many years; her epilepsy was well controlled by medication.

Fifteen years ago the agency would have considered Sallie unadoptable. The medical opinion of the specialist in

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Based on Adoption of Children With Pathology in Their Backgrounds. Child Welfare League of America, 130 E. 22 St., New York 10, N. Y., 1949. 15 pp. 40 cents.

epilepsy consulted by the agency was that the chances are 1 to 50 of a child's developing epilepsy when it is in his background, as against 1 in 200 when it is not. The agency decided that Sallie was adoptable.

Decision left to parents

Before the prospective parents saw Sallie, the agency gave them the medical opinion of the specialist, and also literature available on this disease, leaving them to decide whether they would adopt a child with epilepsy in her background. The agency discussed the medical material with the husband and wife but insisted that they consult a physician independently. The prospective parents studied publications on this subject for laymen, obtained by the agency from the National Association to Control Epilepsy, and discussed the question together for a month.

When Sallie was presented to them they decided to adopt her. They felt that their wish to become her parents, based on authoritative facts and opinions about her family history of epilepsy and on their interest in her as an individual, was genuine. They had no fear of developments in Sallie's future.

The difference here from the first case is that Sallie's problem is a continuing one. The parents had to make the decision, knowing the possible danger of epilepsy's developing. Also the public does not yet accept epilepsy as unreservedly as it does diabetes.

Phyllis, a baby whose mother had a venereal infection

During the pregnancy of Phyllis's mother she was found to have syphilis. Placed under medical care at birth, Phyllis herself was reported free of the disease after tests at frequent intervals. The doctor gave the opinion that follow-up Wassermann tests should continue to be made. The agency gave the complete medical information to the prospective parents. They accepted the facts and the necessity for the follow-up tests.

All agreed that the parents would have to know about the history of syphilis in Phyllis' background, because of the recommendation for check-ups. But, they agreed, the agency should help the parents form and keep a conviction that the prognosis was good because Phyllis herself had never been infected.

The workshop members agreed that all information that would help parents bring up a child must be made available to them. They recommended that study be given to how to tell adoptive parents more than is now being told.

David's mother had a brief mental breakdown

David, a normal, exceedingly attractive child, showed no physical or mental evidence that he might be unadoptable. His parents' histories were normal except for his mother's 2-months' mental illness when David was a few months old. This occurred soon after the stress of her decision to offer David for adoption.

When the mother was released from the mental hospital she came voluntarily to the agency. She discussed the episode freely, took part actively in planning for David, and planned her own future intelligently. Her actions seemed to the agency to be a positive factor in David's heredity.

David was 2 months old when he was placed in a boarding home by the agency. He was observed there for 10 months. He had some feeding difficulties and other slight disturbances such as tenseness, on which the agency obtained medical advice. At 6 months of age he was given a psychological evaluation that placed him in the "average" group. When David was 9 months old the agency pediatrician made an appraisal of the baby's physical development in the light of the information the agency already had. He reported that David was normal and showed no evidence of being unadoptable. His early feeding difficulties and brief periods of tenseness, never serious, gradually disappeared, and he was a happy baby who made friends easily.

David was placed in an adoptive home when he was 13 months old, and adoption completed in 16 months. The decision that he was adoptable was based on the belief that his mother's breakdown was one episode of short duration that followed a severe stress. This information was given the new parents with the complete medical history and all other pertinent facts.

Stevie—whose mother was a dwarf

Stevie's mother was a dwarf with an I. Q. of 63. Little is known of his father. The hospital where the boy was born and stayed for 7 months sent the agency a report that he had shown no signs of abnormality and was apparently developing well.

A psychological evaluation at 7 months showed that he was developing at a high average rate. Stevie was remarkably attractive.

The agency's medical department reported that little is known about the hereditary sequence of this particular dwarfism but the possibility of its transmission to this child was very remote. The department's examination showed the baby to be normal in development and to be physically healthy.

Should children who are themselves in good health lose their chance of adoption because their family history shows disease?

New parents felt they could help

The agency gave the prospective parents all the facts set forth above and the few facts that were known about the father. The agency told them that the mother's family, in spite of difficult economic circumstances, had been very helpful to her while she was making up her mind about giving up Stevie.

The prospective parents said, in making their decision to adopt the boy at 14 months, that they felt they could help Stevie to understand his own heredity and to decide about having children of his own. They were stable individuals who had become very much attached to Stevie as he was.

The workshop's conclusions

In brief, the workshop concluded:

That all children who can benefit by, and contribute to, family life, should be considered adoptable:

That all available medical, psychiatric, and psychological information should be used in enabling the adoption agency to meet its social responsibility.

That all factors in a child's background and personal development, rather than any one in itself, should be considered in determining a child's adoptability;

That an adoption agency should present a child for adoptive placement as soon as its own information about a child is complete and its conviction of the child's adoptability is established;

That prospective adoptive parents are entitled to know everything in the child's background which will affect their function as parents, whether now or in the child's future development:

And finally, that an agency placing for adoption has a deeply felt responsibility to the child, to the adoptive parents, and to the community.

These agencies took part

The participants were representatives of the following agencies: Child Welfare League of America; Catholic Home Bureau, New York City; Family and Children's Society, Montclair, N. J.; Boston Children's Friend Society, Boston, Mass.; Department of Public Welfare, Baltimore, Md.; Child Adoption Committee of the Free Synagogue, New York City; Jewish Child Care Association, New York City; Sheltering Arms Children's Service, New York City; Spence-Chapin Adoption Service, New York City; Children's Aid Society of Pennsylvania, Philadelphia; Child Welfare Division, Department of Public Welfare, New York City; Children's Service Bureau, Brooklyn, N. Y.; Connecticut Children's Aid Society, Hartford; Child Adoption Committee State Charities Aid Association, New York City.

NEGLECTED CHILDREN

(*Continued from page 38*)

neglectful parent; to assume that he is weak and untrustworthy and to get into the habit of doing his job. If this should happen, the basic family pattern would be destroyed, the parents' natural authority over their children and the natural interrelations of parents and children would be damaged perhaps beyond repair. All efforts should be directed toward forming and strengthening ties between these parents and children, or the children might lose their most valuable possession, parents of their own. It should be the parents, not the caseworker, extending hands to help children with one small step in progress, just as they should later be the ones to help their sons and daughters with bigger problems.

First step must be taken

These parents and children who have nothing in common must build up an affection for one another that most fathers and mothers and children have from the children's birth. They must make some move that opens channels of communications between them. It isn't often that a worker happens to see the first step in this movement of parents and children toward one another. I shall never forget one such beginning that took place before my eyes.

The parent was a young father and the children were his 7-year-old daughter and 4-year-old son. The father was just a week out of jail, having served a year's sentence for not supporting his family. Before that he had been in the Navy, also away from home. His wife had just gone off with another man, leaving him with the two children, whom he scarcely knew. Both children were sick with whooping cough, and the father thought of himself as again imprisoned, caring for them. When I visited the home the young man clearly showed his disgust at the situation: and the children looked miserable, partly because of their illness but more because of their feeling of being "lost" children.

Young father faces a dilemma

Their mother had disappeared, leaving them with this stranger who obviously considered them only a burden. I could sense the struggle going on in the father's mind between his feeling of responsibility for the children and the strong urge to get out while the going was good; that is, while someone was around to take over for him. He started by saying that I would have to arrange to place "these kids." He then poured out his feeling about being caught in this impossible situation, about being responsible for children he didn't really know, about his wife—wishing he could have her arrested—about his longing for the peace and quiet of jail after listening to the children's coughing. "They keep *me* awake at night, too."

It was hard to listen to him through this outburst and not reach out to the children. I said that he surely was on the spot; no wonder he wished he were back in jail; of course, he could always go off again, leaving the children. He answered that he "couldn't let them be dumped on the street." I wondered if he were as completely alone in his troubles as he said. Couldn't relatives help? He assured me that there was no one to help and started off again on what a fool he'd been to return here from jail. Look what he'd got into!

Sees child in a new light

While he was making this complaint the little boy wandered into the room, sat on a straight-back chair in a corner, and watched us as we talked. His eyes were puffy, his nose was running. Finally I could stand it no longer and said, "Oh, Tommy, you look as if you'd like to be in bed. I think you have a temperature." His father brushed my remark away with a casual "Oh, no; he's all right." Then he seemed to look at Tommy for the first time; his tone changed and he said, "Come over to me, son." The little boy climbed up on him, stretched out, and fell asleep.

Holding his little son, the father said hesitantly, "You know, I think my dad would help me if I told him how I'm fixed. That is, if he'll forgive me for all the things I've done to disgrace him." I didn't have to worry any more about Tommy and his sister, for they had a real father from then on. When our services were ending and the young man was thanking me, he said solemnly, "But gosh, Miss Smith, you'll never know how close you came to placing my children."

I was careful not to show it, but how well I did know!

I have written mostly about helping parents assume responsibility for their children while the boys and girls stay in their own homes. From a study made of the 137 protective-service cases we brought to an end during the past 2 years, it was found that about two-thirds concluded with the children remaining with their own parents or with relatives, with neglect no longer present.

Parents may have done their best

This is an impressive proportion, although it does not tell the whole story; the story has another aspect. We seldom consider as failures the cases the protective service refers to our children's division for the placement of the children. Sometimes the parents have tried desperately to make the home right for the children but have found that they just haven't enough inner strength or outer resources to do the job.

Sometimes the only parent is ill. Or a widower, trying to keep his children with him, cannot act as father and mother and also support the family. The children in such situations usually rebel at the loneliness and at the load of responsibility; the father may develop an unreasoning determination to preserve the home at all costs. He won't give in now, he says. He's raised the children this far without help and no one is going to take his children from him! (Of course, no one was going to "take his children from him.") The greatest service this family can receive is service that helps the father realize his real responsibility—to decide to ask for different care for his children and take part in planning that care. Under another, more suitable living arrangement, he can be closer to his children than in the rudderless home he had been trying in vain to steer.

Mr. J was one of these fathers. He had been furiously angry at the court action brought against him for neglecting his children. Though his wife was in a mental hospital, unlikely to recover, he felt that he should be allowed to carry on with a very hit-or-miss arrangement for his five small children. He violently refused to work with the staff member of the children's division who receives applications for placement, although his interview with her about foster care was on court order. She referred him to the agency's protective service. We were willing to try out his plan for keeping the children with him, with the understanding that if we decided it was unsatisfactory he might have to return to the children's division to arrange for placement of his children.

We worked together—the service and the father—for several months, and he finally realized that his plan was just no go. When his decision was final, he telephoned to make an appointment with the worker in the children's division whom he had fought so hard. He was to talk with her now about a substitute home for his children.

For the children's good

Before he could keep the appointment he had an accident—he broke his leg. It was the worst possible time for such a misfortune; the injury, anxiety, loss of sleep together sapped the father's strength. But now, convinced that placing the children was the thing to do, he wanted them to gain by it right away. Therefore, as soon as he could, he went on crutches to keep his appointment with the children's division worker who would arrange for foster care. It was a hot day. As he limped awkwardly through the door, looking very haggard, he was unable to push back the locks of hair that fell over his face. The worker scarcely recognized the man who had fought so vigorously months before against what he had now come to ask for. The father saw her startled look, grinned reassuringly, saying, "It's all right, it's really all right. Don't be worried. No more hard words. I feel differently about things now."

Well worth the effort

And so we come back to my original statement that it is awfully hard for parents who are failing their children to take help and finally to become responsible fathers and mothers. It is also hard for social case workers to give this help effectively. It is hard, but to see a neglected child change before one's eyes into a loved child repays every bit of the effort and is worth all the skill that case workers can develop.

Reprints in about 4 weeks

PRENATAL CLINIC

(*Continued from page 35*)

the prenatal period she is often under too great a strain to make the final plan. At this time she needs help from a case worker, and also after the child is born.

It is advisable for the mother to have sufficient time to think her problem through, and sometimes she should wait until the child is actually born, when she is relieved of some of the pressures and when she can see the situation more objectively. Many mothers may need a longer time to decide and may require temporary placement of the child.

During the period of pregnancy, the father should be given an opportunity to be a part of the new family developments. He will be concerned because his wife, at times, seems irritable. He will need help in understanding why this is so and in knowing how he can be helpful. Classes for fathers have proved beneficial to many men, who welcome this opportunity to learn more of what is happening and of their part in the family situation.

To prevent jealousy

When there are other children in the family, they will need to be prepared for the coming baby if rivalry in the family is to be avoided. If the children help in preparing for the baby, and if adjustments within the home affecting them are worked out in advance of the confinement, the children will feel less put out by the existence of the new baby when he is brought home.

The social and emotional problems that exist in the prenatal period are related, therefore, not only to the mother but also to the other children and to the husband, and any adequate plan for prenatal care should include consideration of the total family situation in an effort to prepare the entire family for this new child.

Unfortunate family experiences during the prenatal period will affect the satisfactory progress of the mother. We need to realize that the pregnant woman cannot be separated from the situation in which she finds herself, and that she will be affected by this interaction of feeling between her and the rest of the family.

For this reason, it seems essential that social services should be available in prenatal clinics, as well as psychiatric services for mothers with more serious emotional problems. Since many mothers go through pregnancy happily and look forward to the coming of the child, these services will not be necessary for all mothers. But in every prenatal clinic there are so many mothers who need such help that these consultants would seem essential in providing complete care.

Community resources used

In a general hospital with a prenatal clinic and an obstetric service, a social-service department, if one exists, assists the mothers with such problems, and, in the more serious cases, works closely with the psychiatrist. Such a department, of course, uses all available community resources. Some clinics have no social-service department, but an increasing number of States provide the consultant services of a medical social worker from the department of health, as well as a limited amount of case-work service.

To prevent serious problems later

However, medical social services are really needed as a part of the clinic, because of the serious nature of the problems, the need for frequent interviews with the mother when the social situation is acute, the greater willingness of the mother to talk with the person who is a part of the clinic, and the opportunity of coordinating the social thinking and planning with other community resources. It is hoped that by having social workers and psychiatrists as members of the clinic team, early social and emotional symptoms will be more quickly recognized and treated, thus preventing more serious problems later.

We must help children to be well-born

It has been said that the hope of a nation rests with its children. If we are to have well-adjusted adults to carry on the responsibilities of this complex world, we must start with a generation of children well born; that is, born into a situation where they can have adequate physical care and sufficient emotional satisfaction to ensure sound development of body, mind, and emotions.

Reprints in about 4 weeks

• IN THE NEWS

President Truman Calls Midcentury White House Conference on Children and Youth

On August 31 President Truman formally issued the call for the Midcentury White House Conference on Children and Youth. This is the fifth in a series of such conferences held since the beginning of the century, under the sponsorship of the President of the United States.

That same day the President sent telegrams to all the Governors of the States and Territories, asking each to designate an existing body as the State committee for the conference, or to appoint a new committee for this purpose.

The President also appointed a representative group of 52 prominent citizens to serve as a national committee to make plans for the conference. The committee met September 8 and 9 at the White House and decided on a general plan for the conference. The committee set the time for the Midcentury White House Conference as the week of December 3, 1950.

Reprints Available

A limited quantity of each of the following items, reprinted by the Children's Bureau from the *Social Work Year Book 1949*, is available for distribution. Single copies may be had without charge.

Adoption.
Boys' and Girls' Work.
Camping.
Child Welfare.
Education for Social Work.
Foster Care for Children.
Homemaker Service.
Juvenile and Domestic Relations Courts.
Personnel Standards in Social Work.
Protective Services for Children.
Racial Programs in Social Work.
Recreation.
Social Group Work.
Social Work as a Profession.
Youth Services.

• CALENDAR

Sept. 25–Oct 2—Religious Education Week. Nineteenth annual observance. Sponsored by the International Council of Religious Education. Information from Roy Ross, General Secretary, 206 South Michigan Avenue, Chicago 4, Ill.

Oct. 10–14—American Dietetic Association. Annual meeting. Denver, Colo.

Oct. 13–16—Rural Youth of the U. S. A. Conference. Jackson's Mill, Weston, W. Va.

Oct. 17–20—National League to Promote School Attendance. Thirty-fifth annual convention. New York, N. Y.

Oct. 18–19—Protestant Conference on Child Welfare. Sponsored by the Inter-Agency Committee on Child Welfare, representing the Federal Council of Churches, the Home Missions Council, the International Council of Religious Education, and the United Council of Church Women, Columbus, Ohio. Information from United Council of Church Women, 156 Fifth Avenue, New York 10, N. Y.

Oct. 19–22—Annual conference of The Surgeon General of the Public Health Service and the Chief of the Children's Bureau with the Association of State and Territorial Health Officers, State Mental Health Authorities, and State Hospital Survey and Construction Authorities. Washington, D. C.

Oct. 23–28—National Council of Jewish Women. Nineteenth triennial convention. Baltimore, Md.

Oct. 24–28—American Public Health Association. Seventy-seventh annual meeting. New York, N. Y.

Oct. 24–28—Thirty-seventh National Safety Congress and Exposition. Chicago, Ill.

Nov. 2–5—Second Pan American Congress on Pediatrics. Mexico City, Mexico.

Nov. 6–12—American Education Week. Twenty-ninth annual observance. Sponsored jointly by the National Education Association, the American Legion, the United States Office of Education, and the National Congress of Parents and Teachers. Information from the National Education Association, 1201 Sixteenth Street NW., Washington 6, D. C.

Nov. 7–10—National Society for Crippled Children and Adults. Annual convention. New York, N. Y.

Nov. 17–20—National Council of Negro Women. Annual convention. Washington, D. C.

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Cover, Esther Bubley for Children's Bureau.
Pages 34 and 44, Children's Bureau.
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THIS IS YOUR CONFERENCE

In sending out a call to the Nation for the Midcentury White House Conference on Children and Youth, President Truman offers to everyone in the United States an opportunity to take some part in this great effort for the well-being of children.

This conference does not have its beginning and its end in the meetings of the delegates. The largest part of the preparatory work is being done in communities in the various States. And in this preparation there is useful work for each of us to do. Likewise, after the actual sessions are over, and communities are beginning the next decade's work of carrying out the action programs that the conference has led to, every person interested in children will have a part to play.

The Midcentury Conference is acting on the idea that the people who are closest to the daily lives of children bear the greatest responsibility for them. The conference, therefore, will be guided in large measure by the needs and experience of those who are caring for children day by day. It will be a conference in which lay citizens, professional workers, and public servants thrash out together their separate and mutual problems.

This will be the first White House conference in which young people will take part fully and responsibly. They will participate in the policy-making, sit on committees—National, State, and local—and contribute their ideas, abilities, and skills toward the objectives that they share with adults.

Through joint study from a National, State, and local point of view, the conference will bring together significant knowledge about children, their homes and communities, and it will point to the gaps in our knowledge. It will highlight the paths that we must travel to develop young people who are secure within themselves and equipped for a changing world.

Facts will be assembled on how we can be helped to understand the development of the child in all aspects of his life and how we can preserve and encourage the integrity of each child's person and personality. Against the background of a world and society in great change, the relationships of the child or young person in his family and community, in school, church, and other community institutions, need to be carefully reexamined.

The Midcentury White House Conference will be concerned not merely with ways of correcting and preventing what is wrong, but also with discovering new potentials for sound, healthy, happy childhood, which can be achieved by Nation-wide planning.

Simultaneously with national planning, State planning bodies for children are directing their attention to White House conference activities. In a number of States new planning and action bodies have been created. Right now in some 35 States organizations with concern for broad planning for children are at work. As the result of the President's request to the Governors, it is expected that committees will soon be active in every State and Territory.

A national committee, appointed by President Truman, is now at work under the chairmanship of Oscar R. Ewing, Federal Security Administrator, guiding the conference planning and activities. The program is being carried out with the help of a special staff associated with the Children's Bureau and working closely with other Federal agencies.

But the conference will be what the people of the country make it. And that means you.

If you are a parent, or a member of a club, church, association, union, fraternity, profession, or public or private organization that has a concern for children, there is a part for you to play in this great forward movement for children and youth.

The job for you may be no farther away than your own home. It may lie in group action through your organization, profession, or office.

The strength of this conference will be in the sum total of effort of citizens, working individually and in groups, toward achievement of greater opportunities for every child.

Katharine F. Lenroot

Chief, Children's Bureau

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Oscar R. Ewing, Administrator

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Arthur J. Altmeyer, Commissioner

CHILDREN'S BUREAU
Katharine F. Lenroot, Chief

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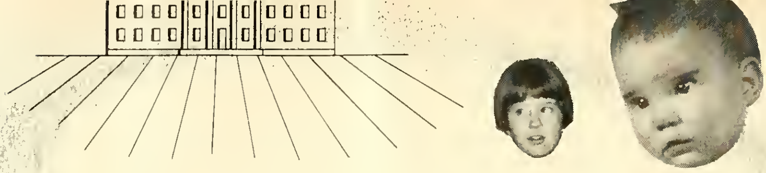

MIDCENTURY WHITE HOUSE CONFERENCE MOVES FORWARD

U. S. SUPERINTENDENT OF DOCUMENTS
NOV 3 1949

I think this rising generation has prospects before it that are really unequaled in the history of the world. And what we want to do is to impress upon them their responsibilities. I think that is the principal reason for this meeting, outlining a program for this future generation that is coming into control of this country and the whole world.

We have been working strenuously since September 2, 1945, for world peace, and that is still our main objective. We are going to get that world peace eventually, and it is going to be a peace we will all be proud of, and under which we can all live and progress.

I am hopeful that some of the things with which we are confronted can be remedied by this conference next year. One of the things that I am vitally interested in is the health of the people of the United States. We discovered in the draft program that 34 percent of the young people who came up for examination for draft purposes were physically or mentally unfit for service.

I think that is rather disgraceful in the richest nation in the world, with all the resources that we have, to neglect the health of the young people. I think that is one of the principal things we want to look after.

Then the other and the most important thing is the mental attitude of these young people. We want them to have the right outlook on life. And in order to do that, they must have proper instruction both at home and in the schools.

You know, if a child has a good mother, and most children do have, and his first three grade teachers are good teachers, who understand the moral outlook as we see it, there is no danger of that child being anything but a good citizen, no matter what happens after that first 8 or 10 years. That is the thing in which I am sure you are vitally interested.

I can't tell you how much I appreciate your interest, shown by your presence here, and I hope that the 1950 conference will be the most important and foward-looking and successful one that we have ever had. And I am sure it will.

And I want to say to you here that you have all the cooperation that goes with the Office of the President of the United States. I won't be running for office next year, and I can do a lot of things that I couldn't ordinarily do.

Harry Truman

Excerpted from the remarks of the President of the United States at the first meeting of the National Committee, Midcentury White House Conference on Children and Youth, held at the White House, Washington, September 8, 1949.

THE TASK OF THE NATIONAL COMMITTEE

OSCAR R. EWING,

Federal Security Administrator
Chairman, National Committee, Midcentury White House Conference on Children and Youth

MAY I EXTEND to you a warm welcome on the occasion of the inauguration of this great national effort in behalf of the Nation's children? I have already expressed personally to President Truman my appreciation for his deep interest in and support of the conference program and for his graciousness in extending to us the hospitality of the White House in holding this meeting.

Recently, as I have walked about the White House and have seen the girders going up, and workmen busily engaged in repairing this historic structure, I wondered whether there would be room for us to meet here. At the same time, the White House provides almost a symbolic setting for us. For the renovation is preserving the structure, the tradition, and the strengths of the White House and at the same time is adding new materials, new mechanical devices resulting from additions to man's knowledge, and new skills in making this a sturdier and a better place in which our Presidents may in the future live.

It seems to me that this is precisely the task before us so far as our children are concerned. We are a great and a strong people. Over the years we have demonstrated that we have not only the physical resources but the capacity and the will to use them to advance the well-being of our Nation and of the world. Our concern for our children is in many ways a continuing symbol of this interest. Through the efforts of voluntary groups, of the Federal Government, of the four previous White House conferences—of citizens everywhere—we have a rich tradition and a record of demonstrated achievement in building healthier, happier, more secure children.

But much remains to be done. The challenge to this committee is to see where our work for children needs shoring up, to ascertain its strengths and weaknesses, to bring to bear man's new knowledge and experience on the problems of children, toward the goal of an ever-better environment in which they may grow in peace and in security.

Solve problems together

You here in this room—members of the National Committee for the Midcentury White House Conference on Children and Youth—come from all walks of life; you represent most of the major interests in our society. The sponsors of this meeting have no preconceived blueprint to hand you that will solve all the problems of children and their parents. We admit fully and frankly that there is a great deal we do not know, and that there is a great deal we know which we do not know how to apply.

We need your broad experience and background. We need your active participation and leadership. With your help, and through you the help of all the people, we hope to work together on some of these problems and move toward better solutions.

If I may, I should like to outline here the work which I think this committee might well undertake.

In the first place, we must chart the broad objectives of the midcentury conference; and secondly, we must devise mechanisms that will accomplish those objectives.

By and large, the 1950 conference should gather together the accumulated experience and wisdom that now exists with respect to the problems of children, particularly what has been gained in the past 10 years. Next, the conference must determine the ways and means that can best be used to make this knowledge available to all those who can use it—parents, professional workers with children, States, communities, and all other individuals and organizations dealing with children and their problems. And perhaps most important to all, the conference should develop its policies and projects with the view of achieving recommendations that will be of value and use in the years following the conference to individuals and organizations concerned with children. Beyond this, the conference should determine those areas which need further research and study and suggest methods whereby these can be carried on.

The President has chosen each member of this committee because he believes each of you has a unique contribution that you can make to the deliberation of the conference and that you can provide leadership in planning its work, in the conference itself and in the follow-up work that must be carried on afterward in order to put its recommendations into practice.

The committee needs to consider at the outset the general theme of the conference, and its focus. Should we undertake detailed examination of all problems relating to children, or rather choose one or more specific problems and concentrate on these? Building on the work of the previous conferences, we might consider giving attention to some particular problem, such as, for example, the growth and development of children in a changing world.

The recommendations of previous conferences were chiefly concerned with social and economic arrangements for the child in the family. Perhaps this was because knowledge of the emotional and psychological aspects of child care and child development were still very much in the making. Although this is still true, considerable advance in recent years has been made, and perhaps the time has come for a full-fledged attack on these aspects of the needs of children.

The magnitude and complexity either of attempting to study all problems of children or of concentrating on one or more is really appalling. There are 46,000,000 children under 18 years of age in the United States. They are part of about one-half of the families of the Nation. They are concentrated in low-income families and low-income States. Three out of five live in families with incomes of less than $2,100. Four out of five live in families with incomes of less than $3,000 a year. One-half of the Nation's children live in 32 States, with only one-third of the national income. Farm families have about 30 percent of the children, but only 11 percent of the national income. Yet the economic problem, important as it is, is far from the whole picture. We live today in a world far more complex than that in which we as youngsters grew up. The tensions are greater, and the demands made upon children for stability and maturity are greater and more difficult to meet.

Our staff will present for your consideration various suggestions for the preparatory work of the conference and for financing it. You are free to accept, reject, or modify each and every one of these suggestions because, in final analysis, this is to be your conference.

The tasks that I have outlined are ambitious ones. As your chairman, I am truly humble in the face of them. I can claim rich first-hand experience as a father and a grandfather. I know the joys and the problems involved. In recent years I have had a chance to know more fully the impact of the total problem of this country, materially wealthy as it is, in providing an environment, a climate—psychological, economic, social, spiritual—in which all our children can grow and develop into healthy, happy citizens.

Contributions will add up

We propose to deal in the conference with the whole child, his health, his education (and that of his parents in dealing with him), his social welfare. Few of us can be expert in all these matters. But in the membership of this committee there is that sum total of knowledge, experience, and passionate concern for

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Given at the first meeting of the National Committee, Midcentury White House Conference on Children and Youth, held at the White House, Washington, September 8, 1949.

the well-being of our children that makes it possible for us to take another great step forward in the over-all study and planning for the needs of children and young people.

This conference is a national study program; but it also envisages follow-up action programs in behalf of children in States and localities throughout the country.

We look to you as members of this National Committee for the unifying force to these activities. You must help provide the knowledge, the leadership, the organization, and the direction to make the conference a success.

We go forward together in an exciting adventure. We need your help. I pledge you my sincere devotion and full support in our common undertaking.

SUMMING UP THE PREVIOUS WHITE HOUSE CONFERENCES

KATHARINE F. LENROOT, *Chief, Children's Bureau*

Secretary, National Committee, Midcentury White House Conference on Children and Youth

IN THE CLOSING year of each decade or the closing year of a new decade in the twentieth century a conference on some phase of the care of children has been held in the Nation's Capital under the sponsorship of the President. One or more sessions have usually been held at the White House. Each conference has included several hundred persons, representing all geographic areas and many varieties of experience and opinion. Although called by the President, with facilities made available by the Federal Government, the White House conferences have not been advisory to any Federal agency or group of agencies. They have been advisory to the American people, and to their representatives in local, State, and national legislative bodies, professional and citizens' associations, public and private agencies.

To strengthen home life

The suggestion for the first White House Conference on the Care of Dependent Children originated with a young lawyer who had been raised in a Washington orphanage. He was impressed by the desirability of a fresh and constructive program in relation to child-caring agencies.

Some 200 persons met at the White House on January 25 to 26, 1909. The period was characterized by a crusading spirit, which inspired courageous action to overcome serious evils threatening child life. For the first time a clarion call sounded throughout the Nation to preserve and strengthen home life for children. Poverty alone should not be a reason for separating a child from his loved ones. The conference declared that "Home life is the highest and finest product of civilization. * * * Children should not be deprived of it except for urgent and compelling reasons." The conference further recommended that if care outside the home is necessary for a normal child, he should be provided for if possible in a substitute home. If institutional care is needed it should be provided in cottage-type institutions approximating as nearly as possible the atmosphere of a home.

Outgrowths of the 1909 conference were the mothers'-pension movement—the precursor of aid to dependent children—improvements in foster care of children, and the creation of a governmental agency—the Children's Bureau—and a national voluntary organization—the Child Welfare League of America.

The 1919 Conference on Child Welfare Standards was the culminating activity of Children's Year, conducted by the Children's Bureau in cooperation with the Women's Committee of the Council of National Defense. This was an era of effort to apply knowledge and concern and crystallize opinion in standards for legislative or administrative action.

In sponsoring Children's Year as a year for special activity for children while the First World War was being brought to a successful conclusion, President Wilson said: "I trust that the work may so successfully develop as to set up certain irreducible minimum standards for the health, education, and work of the American child." The Washington meetings, which began May 5, 1919, were followed by eight regional meetings in various parts of the country. The conference was most influential in relation to the protection of maternity and infancy, which received great impetus through Federal legislation and development of State maternity and infancy programs. The child-labor standards adopted by the conference had an important bearing on Federal and State child-labor legislation.

The 1930 White House Conference on Child Health and Protection was called by President Hoover "to study the present status of the health and well-being of the children of the United States and its possessions; to report what is being done; to recommend what ought to be done and how to do it." The conference chairman was Hon. Ray Lyman Wilbur, Secretary of the Interior. There were four sections, dealing with medical service, public-health service and administration; education and training; and the handicapped. Over 1,200 experts, working in nearly 150 different subcommittees, devoted 16 months to study, research, and fact-finding.

The conference met in November 1930, with 3,000 in attendance, and the medical section met in February 1931. A Children's Charter was adopted which has had wide influence. The findings of the conference were reported in 32 volumes.

Writing of this conference, Homer Folks, a leader in the 1940 as well as the

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Given at the first meeting of the National Committee, Midcentury White House Conference on Children and Youth, held at the White House, Washington, September 8, 1949.

1930 and earlier conferences, said: "It was an era of detailed fact-finding and report-making, including the reports of the President's Committees on Recent Economic Changes and on Social Trends."

With the exception of the challenging statement of general goals toward which to strive in the form of the Children's Charter, it was impossible, in Mr. Folks' words, "to condense and coordinate the findings or recommendations into a composite whole, or to convert such material into a program of action for children."

Results hard to measure

Truly to assess the results of the conference it would be necessary (1) to evaluate the stimulus given citizens' organizations throughout the country, such, for example, as the parent-teacher associations and women's clubs, whose concern for children was greatly augmented by the conference; (2) to trace the effect of the conference in enriching concepts basic to the further development of programs for children, such, for example, as understanding of the factors in growth and development of children; enhancing interest in preventive pediatrics and the training of pediatricians and other medical personnel; directing attention to family life, with particular reference to the need for further research, especially in relation to economic and social factors, and to parent education and family consultation service; and developing new insights into juvenile delinquency; and (3) to review the activities of State follow-up programs, which were organized in many States and which frequently represented the first State-wide attempt to bring together various professional groups and functional agencies, public and private, in reviewing children's needs and improving children's services. One of the outstanding results of the conference work was a great advance in the field of pediatrics and pediatric education.

Radio brings conference to parents

The 1930 conference was able for the first time to utilize the radio in bringing millions of mothers and fathers within range of the conference session. President Hoover in his address to the conference referred to these "unseen millions listening in their homes, who likewise are truly members of the conference." He said: "Let no one believe that these are questions which should not stir a Nation; that they are below the dignity of statesmen or governments. If we could have but one generation of properly born, trained, educated and healthy children, a thousand other problems of government would vanish."

The fourth White House Conference was held in 1940, with a preliminary session at the White House in April 1939 to plan the conference activities. President Franklin D. Roosevelt asked the conference to consider two things: "How a democracy can best serve its children; and, the corollary, how children can best be helped to grow into the kind of citizens who will know how to preserve and protect our democracy." The Secretary of Labor, Frances Perkins, was chairman of this White House Conference on Children in a Democracy. The conference was organized and guided by a planning committee composed of some 70 persons, a committee on organization, and a report committee of 27 members, aided by a research staff, and a series of groups of experts. The subject matter was widely inclusive of the major factors affecting the children of America, including the characteristics of American family life, incomes of families, their dwellings, and their assistance in times of need; education, primarily the school system; child labor and youth employment; health and medical care; leisure-time services; social services; religion and children in a democracy; minority groups. The results of the conference work were published in a general report, which included 98 recommendations, and a more detailed final report.

MIDCENTURY WHITE HOUSE CONFERENCE on CHILDREN and YOUTH to be held the week of

★ DECEMBER 3, 1950 ★

The last session of the conference was devoted to consideration of follow-up activities. Nationally, the plan adopted proposed the creation of a nongovernmental National Citizens' Committee, to which responsibility would be given for leadership in the follow-up program, and a Federal Inter-Agency Committee. The latter, composed of representatives of 30 Federal agencies, was organized in March 1940 for the purpose of coordinating the work of Federal Departments in cooperation with the National Citizens' Committee and State and local follow-up programs. The organization of the National Citizens' Committee, comprising 25 members, was completed on June 17, 1940. Within a few months follow-up activities had been begun in a number of States. Both the National and the State committees, however, were almost at once engulfed in considerations of national defense and later in wartime activities, and gradually the White House Conference work for the most part lost its identity, as efforts were merged in defense and war work.

It can be said, however, that real leadership was given by the National Citizens' Committee in the first 2 years following the conference in keeping the needs of children before the Nation, and that the follow-up work in many States gave great impetus to State-wide and community planning for children which has persisted and gained recognition throughout the war years and to the present times.

We learn from experience

In reviewing briefly the experience of four decennial conferences, certain points emerge which should be of value in laying plans for the fifth, the Midcentury Conference.

First, as to scope: The first two conferences were probably too limited in scope, but the last two covered such a broad range of subjects as to make it difficult for a clear-cut, understandable program to emerge which could be the basis for action in behalf of children.

Certainly there is need for recognition of the inclusiveness of concern for children, but there must be sharply defined focal points around which the conference program can be built, as well as careful selection of subjects that will receive major attention.

Second, adequate staff and financing are essential to maximum results. The 1930 conference had by far the greatest resources, and is generally held to have been the most successful.

Third, previous conferences tended to be overbalanced in membership by experts and in subject matter by program formulation, with insufficient representation of citizens and consideration of how programs can be translated into action.

Fourth, although the 1930 and 1940 conferences had definitely organized follow-up programs centered on State and community action, their membership was not sufficiently related to leadership for follow-up programs in States and local communities, nor was such leadership sufficiently involved in preconference activities. In other words, structure had to be improvised and leadership mobilized following the conference, instead of the National program growing out of a large amount of State and local inquiry, review, recommendation, and action.

TO FOCUS ON CHILD'S MENTAL, EMOTIONAL, AND SPIRITUAL GROWTH AND DEVELOPMENT

MELVIN A. GLASSER

Executive Director, Midcentury White House Conference on Children and Youth

WHEN PRESIDENT TRUMAN, on August 31, formally issued the call for the Midcentury White House Conference on Children and Youth, more than 2 years of preliminary work was brought to a head. Planning bodies in nearly all the States and Territories, leading citizens and representatives of diverse national organizations, and staff members of Federal departments concerned with children and youth had pooled their thinking and the resources of their organizations to build a foundation on which this fifth decennial conference could rise.

A new type of conference

The 1950 conference is a bold venture into new and uncharted realms. It is tackling the problems of child growth from a new direction; it is a conference that, in its *preparatory* phase, is enlisting participation from State-wide and community groups. Participation from individuals in all walks of life is being sought.

Immediately upon calling the conference, the President sent the following telegram to the Governors of each of the States and Territories and the Commissioners of the District of Columbia:

"I have called a Midcentury White House Conference on Children and Youth and have appointed a committee of distinguished citizens to give general direction to the undertaking, under the Chairmanship of Honorable Oscar R. Ewing, Federal Security Administrator.

"The value of this conference will depend upon full participation of each State. Mr. Ewing will communicate to you a suggestion that you either designate an existing body broadly representative in your State or appoint a State committee to serve for this conference. I shall personally appreciate your cooperation in making the conference an outstanding contribution to child life in America."

The response at this writing indicates that the States are rapidly developing their committees to cooperate in the undertaking. State and local activities will be represented in the preparatory work by an advisory council on State and local action, which will report directly to the National Committee.

National organizations, through their programs, are expected to make significant contributions to the White House Conference projects. In many will be found resources of knowledge, experience, technical skill, and citizen leadership that will be invaluable to the conference activities. One of the ways through which this participation will be secured is through an advisory council of national organizations, lay and professional, which should provide a common meeting ground for cross-fertilization of experience and ideas.

Communications program established

The effective development of preliminary work requires that information concerning conference plans and objectives be brought directly to all who are concerned with children and with problems relating to child growth. Furthermore, it is essential that information made available to the National Committee from groups throughout the country should be carefully integrated and interpreted in usable form if follow-up programs are to be encouraged. Special attention therefore is being directed toward developing at the outset a communications program which provides not only for full publicity but also for carefully designed and directed program material.

The National Committee recognized that the knowledge, experience, and resources of the Federal agencies working with children would be an invaluable asset to the conference work in fact finding, in communications, in State and local action, and in all other aspects of the program. Accordingly, the committee recommended that an advisory council on Federal Government participation be set up as an integral part of the conference structure.

This Midcentury White House Conference is unique, too, in that it is not only a conference about and for children and young people: it is the first in which youth participation is an integral part of the planning. Not only are several young people actual members of the National Committee, but a special advisory council on youth participation is being organized to develop principles for, and methods of, participation by young people in all aspects of the conference activities, National, State, and local.

One of the major decisions made at the September 8–9 meeting of the National Committee of the Midcentury White House Conference on Children and Youth was to adopt a conference theme—a focus around which would be centered the conference emphasis, program, and activities. After vigorous discussion of the many problems of children and young people that require major study and action, the National Committee adopted the following conference theme:

The Midcentury White House Conference on Children and Youth bases its concern for children on the primacy of spiritual values, democratic practice, and the dignity and worth of every individual. Accordingly, the purpose of the conference shall be to consider how we can develop in children the mental, emotional, and spiritual qualities essential to individual happiness and to responsible citizenship.

To do this the conference shall—

(*a*) bring together in usable form pertinent knowledge related to the development of children, and indicate areas in which further knowledge is needed;

(*b*) examine the environment in which children are growing up, with a view to determining its influence upon them;

(*c*) study the ways in which the home, the school, the church, welfare agencies and other social institutions, individually and cooperatively, are serving the needs of children;

(*d*) formulate, through cooperative efforts of laymen and specialists, proposals for the improvement of parental, environmental, and institutional influences on children;

(*e*) suggest means whereby these proposals may be communicated to the people and put into action.

Committee adopts organization plan

The National Committee recognized that in order to make this a truly representative conference a plan of organization needed to be worked out that would provide an opportunity for the citizens of this country to participate fully. Accordingly the plan of organization charted on pages 56–57 was adopted.

The members of the National Committee for the Midcentury White House Conference on Children and Youth, comprised of 52 educators, physicians, clergymen, businessmen, economists, and civic, labor, and farm leaders (appointed by President Truman August 29, 1949) are:

Dr. Raymond B. Allen
President, University of Washington
Seattle, Wash.

Francis Bacon
Professor of Secondary Education
University of California at Los Angeles
Los Angeles, Calif.

Charline Banks (youth representative)
236 Marion Street
Brooklyn, N. Y.

Harvie Branscomb
Chancellor, Vanderbilt University
Nashville, Tenn.

A. J. Brumbaugh
Vice President, American Council on Education
744 Jackson Place NW.
Washington 6, D. C.

Lyman Bryson
Counsellor on Public Affairs
Columbia Broadcasting System
485 Madison Avenue
New York, N. Y.

Mrs. J. L. Blair Buck
President, General Federation of Women's Clubs
1734 N Street NW.
Washington 6, D. C.

James Carey
National Secretary-Treasurer, CIO
718 Jackson Place NW.
Washington 6, D. C.

Chris L. Christensen
Vice President, Director
Celotex Corporation
120 South LaSalle Street
Chicago, Ill.

Mrs. Jerome Evanson
Director of Education for the North Dakota Farmers Union
Jamestown, N. Dak.

Hon. Oscar R. Ewing (chairman)
Federal Security Administrator
Washington, D. C.

Katharine E. Faville
Dean of College of Nursing
Wayne University
Detroit, Mich.

Lawrence K. Frank
Director, Caroline Zachry Institute of Human Development
17 East Ninety-sixth Street
New York 28, N. Y.

Rabbi Solomon Goldman
3760 Pinegrove Avenue
Chicago 13, Ill.

Shelby M. Harrison
370 Riverside Drive
New York 25, N. Y.

Mrs. John E. Hayes
President, National Congress of Parents and Teachers
600 South Michigan Boulevard
Chicago, Ill.

Dr. Charles Janeway
Professor of Pediatrics, Harvard University Medical School
300 Longwood Avenue
Boston 15, Mass.

The Rev. Raymond B. Johnson
Minister, First Parish Church
40 Middle Street
Hingham, Mass.

Dr. T. Duckett Jones
Medical Director, Helen Hay Whitney Foundation
525 East Sixty-eighth Street
New York, N. Y.

Flemmie P. Kittrell
Head of the Department of Home Economics
Howard University
Washington, D. C.

The Rev. C. E. Krumbholz
Executive Secretary, Division of Welfare
National Lutheran Council
231 Madison Avenue
New York 16, N. Y.

Mary Leeper
Executive Secretary
Association for Childhood Education International
1200 Fifteenth Street N. W.
Washington, D. C.

Mrs. David M. Levy
Citizens' Committee on Children of New York City, Inc.
136 East Fifty-seventh Street
New York, N. Y.

Eduard C. Lindeman
235 East Twenty-second Street
New York, N. Y.

The Very Rev. Msgr. John J. McClafferty
Dean of the National Catholic School of Social Service
Catholic University
Washington, D. C.

Chauncey McCormick
Chairman of the Board, Illinois Children's Home and Aid Society
410 North Michigan Avenue
Chicago 11, Ill.

(Continued on page 61)

MIDCENTURY WHITE HOUSE CO

Organization ac

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Honorary Chairman —Pres
Chairman —Hon.
Vice Chairmen —Leon
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Secretary —Kath

Exec

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Chairman-

A. J. Brumbaugh
Lyman Bryson
James Carey
Hon. Oscar R. Ewing, *ex offici*
Rabbi Solomon Goldman
Mrs. John E. Hayes
T. Duckett Jones, M. D.
Flemmie P. Kittrell

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Advisory councils

(Members to be appointed by the executive committee)

Advisory council on participation of national organizations:

Four National Committee members *and* representatives of national organizations from outside the National Committee. Chairman to be elected by advisory council.

Advisory council on Federal Government participation:

Four National Committee members *and* representatives of Federal agencies. Chairman to be elected by advisory council.

Advisory council on State and local action:

Four National Committee members *and* representatives of State and Territorial White House Conference Committees. Chairman to be elected by advisory council.

Advisory council on youth particip tion:

Four National Committ members *and* representativ of youth organization Chairman to be elected l advisory council.

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Mrs. David M. Levy
The Very Rev. Msgr. John J. McClafferty
Mrs. Eleanor Roosevelt
Boris Shishkin
Benjamin Spock, M. D.
George D. Stoddard
The Rev. Luther Weigle

be filled

Technical and special committees

(Members to be appointed by the executive committee)

Technical committee on fact-finding: Four National Committee members *and* about 20 others. Chairman (elected by committee), Benjamin Youngdahl.

Technical committee on communications: Four National Committee members *and* about 20 others. Chairman (elected by committee), Lyman Bryson.

Committee on conference program: Twelve National Committee members. Chairman (elected by committee), A. J. Brumbaugh.

Committee on budget and finance: Seven National Committee members *and* others to be added to assist in fund raising. Chairman to be elected by committee.

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WEST VIRGINIA SETS UP A COUNTY DEMONSTRATION PROGRAM FOR SAVING PREMATURE BABIES

HALLIE ISABEL MORGAN, M. D., M. P. H. *Director, Division of Maternal and Child Hygiene, West Virginia State Department of Health, Charleston*

WHEN Dr. N. H. Dyer became Commissioner of the State Department of Health in October 1946, West Virginia had been without a Director of Maternal and Child Hygiene since 1941, except for two brief intervals. Thus, when the writer accepted that position, early in 1947, there was much basic planning for us to do.

After surveying West Virginia's infant and maternal mortality rates over a 3-year period we were faced with the fact that our infant death rate was 30 percent worse than the rate for the United States as a whole. Only three States had worse infant death rates than West Virginia. And some counties in the State had an infant death rate 50 percent higher than the rate for the Nation.

We found also that, although all the States had regrettably high rates for deaths caused by premature birth (and it leads all causes of infant deaths in every State), West Virginia's was one of the highest. Besides, we had reason to believe that our reporting was inadequate, and we felt sure that the figures available did not show the magnitude of the problem.

Accordingly, we decided that the best way for us to reduce the infant mortality rate would be to save as many premature babies as possible.

All of these babies were extremely small when born. They were cared for in a special premature-baby unit in the hospital until they weighed at least 5½ pounds. Here the babies are shown on a return visit to the hospital, which maintains a well-baby clinic for prematures.

In practically every State of the Union the State health department is carrying on some kind of program for saving the lives of premature babies, and most of these programs are assisted by Federal grant-in-aid funds under the Social Security Act. The programs for this purpose in the various States vary greatly, as State programs do in every field. They range from State-wide programs of complete care, including after-care in the home, to small beginnings, such as training a few hospital and public-health nurses in methods of caring for premature babies, or lending incubators to some hospitals. Health authorities in a number of States have shown great interest in the steps that the other States are taking toward saving these babies. For this reason *The Child* is hoping to publish information from various States on the development of their programs.

Advisory committees help

At this point we felt that we needed to consult with the medical profession in our own State, and so we called in the chairmen of two of our advisory committees—on care of mothers and on care of babies—these represented the State medical association. Together we went over the problem.

Our discussion led us to agree that we must choose a program that would give the best results possible with our limited personnel, facilities, and funds. We knew, of course, that a State-wide program was out of the question, and so we decided to set up a demonstration project in the county in which the State capital, Charleston, is located—that is, Kanawha County.

We chose the newest hospital in the county, the community-owned Herbert J. Thomas Memorial Hospital, in South Charleston, 7 miles from Charleston.

We knew that the space allotted in the hospital must be separate from the nursery for the other newborn babies, and that the program would be expensive as compared to the cost of caring for other newborn babies, because we would need specially trained nurses and more hours of nursing service, as well as special equipment.

We asked the chairman of our advisory committee on child welfare, who is a busy practicing pediatrician, to go to Chicago to study the program at the Michael Reese Hospital. After some time, she returned, eager to assist with a similar program in West Virginia. She could not give up her practice, but she agreed to come into the Division of Maternal and Child Hygiene as a part-time consultant and to take charge of the medical aspects of the premature-baby program. Our advisory chairman also undertook the important and difficult task of interesting the local doctors and nurses in the program for saving premature babies.

We buy our equipment

Next we faced the decision as to what must be purchased. Large expenditures for equipment hardly seemed warranted, for the possibility of acquiring the necessary specially trained nurses appeared remote. However, with a great deal of faith that the nurses' training would be obtained, we proceeded to buy material for a premature-baby unit, consisting of eight incubators and three bassinets. And since our unit was far from the Charleston hospitals, we knew that an ambulance would be essential, and we started on the hunt for one. None of Charleston's automobile dealers could help us, because the delivery of new cars was still reflecting wartime conditions. But after an undertaking establishment in the city gave us the name of a reliable firm in Illinois, we successfully placed an order for an ambulance, and the firm agreed to deliver it within 7 or 8 months.

Using space efficiently

We next concentrated on reconstructing the space that the hospital had allotted for our use. It consisted of a room 23 feet long and 16 feet wide. To fulfill the minimum standards we would have to set up not only the nursery itself, but also a nurses' station, a clean workroom, and an observation room with at least three bassinets for babies born elsewhere than in this hospital. And we would have to allow, in the nursery, an average of 20 square feet for each of the premature infants.

The isolation and observation room has space for three incubators and a respirator. A premature baby born outside the hospital is placed here for 72 hours, so that we can be sure he has no infection that the other babies could acquire from him.

Incubators and bassinets

The main nursery has room for eight babies, five of them in incubators and three in bassinets. (When a baby reaches a certain weight, he is transferred from an incubator to a bassinet.)

These healthy triplets were weak little prematures not so long ago. They were cared for in the special nursery unit established in the Thomas Memorial Hospital, Kanawha County, W. Va., by the Division of Maternal and Child Hygiene of the State Department of Health.

Our next problem was: How could we keep the individual equipment for each baby separate from every other baby's? Bedside cabinets were out of the question in such a small space, and the type of incubator that has a compartment for the baby's supplies had not yet been placed on the market. With the help of a local cabinetmaker, we solved that problem by designing a cabinet ourselves, and having one fitted into the space beneath each incubator.

Another problem was how to supply the oxygen that these small babies need. It would be necessary to convey oxygen from some kind of container to each incubator. We certainly did not favor the old plan of having the nurses scrub an oxygen tank (so as to avoid bringing infection into the nursery) and wheel it up to the incubators, one by one. Providence was with us again, for just outside our nursery unit is a loading platform. We had an oxygen firm provide a 10-cylinder oxygen manifold and place it on the platform. Feeder lines lead from these tanks into the nursery and are attached to the incubators. By means of a flowmeter, the nurses can see how much oxygen is going to each baby and can control the amount.

Then we needed to provide for terminal sterilization of milk mixtures. The hospital did not have facilities for this process, and so we decided, with the help and advice of a sterilizing equipment company, to use the same formula room as was used for the other newborn babies' milk mixtures, and to install an autoclave and a sterile water tank. (After we give terminal sterilization to the milk mixtures, we put the bottles in the refrigerator in the premature unit.)

We learn from Illinois

Our main problem, however, was to find and train the right nurses. In October 1947 we sent three carefully selected nurses to the Michael Reese Hospital in Chicago, for a 6 weeks' intensive course in the care of premature babies. These nurses also spent 2 weeks in the field with the nurses on the staff of the Illinois State Department of Public Health, going into the homes of premature babies so that they could see at first hand how the Illinois State program worked. On their return to West Virginia, two of the nurses accepted staff duty until the unit opened, and the nurse selected to supervise the unit assisted with final organization plans and wrote a manual of nursing procedures as adapted to our facilities and equipment.

Pediatricians deserve credit

During these months, the chairman of the advisory committee on child welfare was engaged in "selling" the program to the other pediatricians in the county and in organizing them into a working unit. I cannot give too much credit to the Kanawha County pediatricians who agreed to take 3 months' rotating service in the premature-baby unit. They held many time-consuming meetings, at which standard procedures were agreed upon. This was done so that when one pediatrician yields the service to another, there need be no break in technique. From the very beginning the pediatricians of Kanawha County have shown how valuable organized community health service can be.

Socio-economic histories sought

During these months, we in the Division of Maternal and Child Hygiene were directing our efforts toward providing smooth administration. For example, we studied the application forms used by other premature-baby units and drew rather heavily on the Illinois system. We enlarged one form, adding spaces for the socio-economic history of the baby's family, and we feel we have gained much knowledge from its use.

Working closely with us during this whole period of planning were the city-county health officer and his staff of public-health nurses.

By December 1947 we were within sight of our goal, but reconstruction of the nursery was taking longer than we had anticipated.

One gray wintry morning that month, we learned that our ambulance was en route to us and would arrive in Charleston before the office closed next day! What were we to do with it? Our program could not be begun for another 2 months at least, and we had not yet planned to use the ambulance. At this point one of our nurses showed that she was also a good public-relations worker by suggesting that we ask one of the local automobile agencies to display the ambulance in a show window for us, together with a sign explaining its use. The dealer agreed to do this as a community service.

A newspaper helps us

Later that month we arranged with a newspaper to publish an article telling the purpose of the ambulance, and explaining the need for saving the lives of premature babies in the county and the State. The article was accompanied by a picture of the ambulance and of workers on the program.

Mortality of premature babies cared for in Herbert J. Thomas Memorial Hospital, South Charleston, W. Va., by birth-weight groups.

(From Dec. 19, 1947, to Apr. 20, 1949)

Birth weight	Total	Lived	Died	Percent mortality
1,000 gm. (2 lb., 3 oz.) or less	25	6	19	76.0
1,001 gm. to 1,500 gm. (3 lb. 4 oz.)	31	16	15	48.4
1,501 gm. to 2,000 gm. (4 lb. 6 oz.)	79	67	12	15.2
2,001 gm. to 2,500 gm. (5 lb. 8 oz.)	10	6	4	40.0

The percentages in this table are of limited statistical dependability because the number of infants concerned is small. However, we are presenting the figures to show the type of information that is helpful in evaluating experience under such a program. As the program is continued over a longer period, there will be a large enough number of premature infants cared for to enable us to make more satisfactory estimates of mortality among them.

Later, after the program started, we accepted the services of the staff of the Charleston Fire Department, who offered to store and drive our ambulance. Since then, the firemen have been our faithful allies in the program, and they have had much to do with its success.

A few days after the newspaper article appeared, we received a call from a general practitioner about 10 miles from town, reporting the birth of a premature baby at home. If he brought it to the hospital, would we try to save it?

The program opens

Our pediatric consultant was with me at the time, and I turned to repeat the conversation to her. She said: "But our quarters won't be ready for another 2 months! Perhaps the hospital will let us put one of our incubators on the pediatric floor."

"It might be," I answered, "and goodness knows we'll have to take our first baby some time." Solemnly I raised my right hand and said, "I hereby declare the Premature Baby Program of Kanawha County open!"

Yes; our first baby lived.

In February of 1948 our quarters were ready, and the program opened officially.

We spent about $50,000 on the entire program up to April 20, 1949. The cost for each baby averaged $341.70.

Of the 145 babies admitted, 105 lived more than 48 hours; they had an average birth weight of 1,361 grams (3 pounds) and required an average of 28 days of nursery care. No baby was sent home until he weighed at least 5 pounds and until the public-health nurse was certain that the parents were equipped to care for him.

Our ambulance proves valuable

Nearly one-fifth of the babies cared for in our unit were born at Thomas Memorial Hospital, more than half were born in Charleston hospitals, and more than one-fifth were born at home. Our ambulance brought more than two-thirds of the babies to the nursery from various parts of the county. Sixteen multiple births were represented. We had one set of triplets.

The mortality among these 145 babies by birth-weight groups is shown in the table on this page.

Sixty-two of Kanawha County's physicians have sent premature babies to our unit. This amounted to about half of the county's general practitioners and most of its obstetricians.

Our plan was to let the parents pay for all or part of the baby's care if they could afford it. If they could not, our Division was to pay the hospital $18.45

a day; recently this has been cut to $16.80 a day.

Study of the families consistently showed the parents to be in the lower-income group ($65 weekly on the average). They were also in the younger group, the average age of the fathers being 27 and that of the mothers, 22. Most of the families have from three to four dependents.

Most of the parents could not pay

With the help of the Children's Bureau, we have carefully evaluated the socio-economic histories of the parents and found that if our division had assumed a fee-collecting role, we would have been able to collect from three sources, and then only (since these infants died early) the amount of $500.

We all realize that care of the premature is an emergency task. And we know also that prematurity in many instances can be prevented through good prenatal care and adequate nutrition. This latter is important not only during the months of pregnancy, but also, and even more so, during the growing period of young girls, who are the future mothers. Our nutrition chief has begun to study the diet habits of the mothers of our premature babies.

We have found that the service given to the community by such a program as ours can and does become a medium of effective education in public health.

Healthy, happy babies

We held a well-child conference for our first group of premature "graduates" in June 1949. Twenty-seven babies were examined by the pediatricians who had cared for them during their first fight for life. It was a real thrill for us to see the healthy, happy condition of these youngsters. And never have I seen a group of babies better cared for or more truly loved. Don't ever let anyone tell you that one of these babies isn't wanted just as much as a normal baby. A talk with the parents convinced me that they knew something of child care and development. Could it have been my imagination that these babies seemed more contented, less fussy, and blessed with happier dispositions than many?

Reprints in about 4 weeks

Committee adopts organization plan

(Continued from page 55)

Leonard W. Mayo
Chairman, National Commission on Children and Youth
Director of the Association for the Aid of Crippled Children of New York
580 Fifth Avenue
New York, N. Y.

Benjamin E. Mays
President, Morehouse College
Atlanta, Ga.

Dr. William Menninger
Menninger Clinic
Member of Board of Directors and General Secretary
Menninger Foundation
Topeka, Kans.

Mrs. Agnes E. Meyer
The Washington Post
Washington, D. C.

Mabel Newcomer
Chairman, Department of Economics
Vassar College
Poughkeepsie, N. Y.

Herman Neusch (youth representative)
Senior, George Washington University
Home, Amarillo, Tex.

Pauline Newman
Educational Director
Union Health Center
International Ladies' Garment Workers Union (A. F. of L.)
275 Seventh Avenue
New York 1, N. Y.

Emma C. Puschner
National Child Welfare Director
American Legion
777 Meridian Street
Indianapolis, Ind.

Walter Reuther
International President, United Automobile Workers of America (C. I. O.)
411 West Milwaukee Street
Detroit 2, Mich.

Max Rheinstein
Professor of Law
University of Chicago Law School
Chicago, Ill.

Mrs. Eleanor Roosevelt
United States Representative to UN General Assembly
Chairman, Commission on Human Rights UN ECOSOC
Hyde Park, Dutchess County, N. Y.

Helen Ross
Administrative Director
Institute for Psychoanalysis
664 North Michigan Avenue
Chicago 11, Ill.

Ruth Schaffer (youth representative)
949 Berkeley Road
Columbus, Ohio

Dr. Edward B. Shaw
Chief, Department of Communicable Diseases, Children's Hospital
Associate Clinical Professor of Pediatrics
University of California Medical School
San Francisco, Calif.

G. Howland Shaw
2723 N Street NW.
Washington, D. C.

Boris Shishkin
Economist, American Federation of Labor
901 Massachusetts Avenue NW.
Washington, D. C.

Dr. Benjamin Spock
Pediatrician, Department of Psychiatry
Mayo Clinic
Rochester, Minn.

George D. Stoddard
President, University of Illinois
Urbana, Ill.

Donald F. Sullivan (youth representative)
1908 Irving Street NE.
Washington, D. C.

Gerard Swope
Honorary President
General Electric Co.
570 Lexington Avenue
New York, N. Y.

Mrs. Phyllis Jones Tilley
Florida Normal College
St. Augustine, Fla.

Edward M. M. Warburg
Chairman, American Joint Distribution Committee
280 Madison Avenue
New York, N. Y.

Mrs. Roy C. F. Weagly
R. R. 1
Hagerstown, Md.

The Rev. Luther Weigle
President, International Council of Religious Education
142 Cold Spring Street
New Haven, Conn.

John Wood (youth representative)
Junior, Union Theological Seminary
975 Walton Avenue
Bronx 25, N. Y.

Benjamin E. Youngdahl
Dean, School of Social Work
Washington University
Skinker and Lindell
St. Louis, Mo.

Reprints in about 4 weeks

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"A fair chance for everyone does not begin with adult life nor with infancy. Its mysterious springs are more and more swathed in mystery as we push backward from the man, the youth, the child, the baby, to the endless line of the generations out of which each living being emerges in his turn."

Julia C. Lathrop, 1919.

IN THE NEWS

Three States Raise Child-Labor Standards

This year the legislatures of three States, Maine, Tennessee, and Alaska, materially strengthened their child-labor standards. Maine and Tennessee became the twenty-first and twenty-second States to set a basic minimum age of 16 years for employment of children. (The States that have a basic minimum-age standard set a 16-year minimum age either for factory employment at any time or for all work during school hours, except, in some States, in agriculture or domestic service. A few States meet both standards.)

In both Tennessee and Maine the new laws set 16 as the minimum age for employment at any time in any manufacturing or mechanical establishment. Formerly the minimum was 15 in Maine and 14 in Tennessee. The Tennessee act also raises the minimum age from 14 to 16 for employment during school hours in any gainful occupation except agriculture and domestic service. Maine retains its former minimum age of 15 for work during school hours; but sets 16 for employment at any time in hotels and places of amusement, and 15 in stores and in eating places.

Both States set a minimum age of 16 for work in bowling alleys. Formerly Maine prohibited this work for boys and girls under 15; and Tennessee applied no minimum age outside school hours. Tennessee now prohibits a number of specified hazardous occupations for minors under 18, rather than under 16 as formerly. In Maine, dry-cleaning establishments have been added to the places in which occupations may be declared hazardous for minors under 18 by the commissioner of labor and industry.

Through this legislation both States also improve the former maximum hours-of-work standards. Tennessee adopted an 8-hour day and a 40-hour, 6-day week as the maximum for minors under 18 in any gainful occupation. Previously it had as a maximum an 8-hour day and a 48-hour, 6-day week, which applied only to minors under 16 in specified occupations. The new Maine act applies its standard of a maximum 8-hour day and 48-hour, 6-day week to boys and girls under 16 instead of only to those under 15 as formerly. In both States, also, special regulations will now apply to employed children under 16 who are attending school as well as working. Maine now limits the hours of employment of such children to 4 hours a day and 28 hours a week, and Tennessee to 3 hours a day and 18 hours a week. The Tennessee act prohibits the work of minors under 16 between 7 p. m. and 7 a. m., instead of 6 p. m. to 6 a. m., as formerly. It also prohibits the work of minors 16 and 17 between 10 p. m. and 6 a. m. Under the former law, messenger work was the only night work prohibited for minors 16 and 17.

Alaska's child-labor law up to this year consisted of a minimum-age requirement of 16 years for girls only, applying to those employed in any mercantile or industrial establishment. This provision is retained under the new law, which in addition sets a minimum age of 16 for employment of boys in restaurants, hotels, or lodging houses. The new law also authorizes the Territorial commissioner of labor to establish standards relating to the kind and extent of work and safe working conditions of minors. Under this authority a 16-year minimum age in manufacturing and processing operations, as well as certain other occupations, was set by regulation, which went into effect July 16, 1949. For all other gainful employment, except domestic service and baby sitting, the act sets a minimum age of 14.

Children's Fund Gets Soap From New Zealand

Another shipment of 86,240 pounds of soap from this country for the relief of needy children in Europe and the Middle East has increased to almost half a million pounds the amount of soap dispatched from New Zealand by the United Nations International Children's Emergency Fund (UNICEF).

Practically unavailable in the period immediately following the war, soap remains in extremely short supply in many countries. UNICEF field missions point out that this lack of soap is a contributing factor to the ever-present threat of disease, particularly the overcrowded, unsanitary Middle East refugee camps.

Soap shipments from New Zealand to European and Middle Eastern countries, where children and nursing mothers are receiving UNICEF aid, are generally distributed among mothers of newborn babies, orphans, welfare institutions, and others receiving medical treatment under projects sponsored by the Fund and the United Nations World Health Organization.

To Keep Birth Records Confidential

The House of Delegates of the American Medical Association, at its 1949 meeting at Atlantic City, N. J., adopted resolutions urging State legislatures and registration officials to take steps toward establishing a policy of keeping birth records confidential.

The resolutions are as follows:

Whereas physicians attending at births are required by the respective State laws to complete and file a certificate of birth, and have an interest in seeing that the confidential nature of the birth certificate is maintained and that none of the data contained therein are used to the detriment or embarrassment of the child and family concerned: Therefore be it

Resolved, That the American Medical Association commends the efforts of the American Association of Registration Executives, the Council on Vital Records and Statistics, the Children's Bureau, and the National Office of Vital Statistics of the Federal Security Agency to formulate a policy maintaining the confidential nature of birth records, which was published in January 1949 under the title "The Confidential Nature of Birth Records"; and be it further

Resolved, That the American Medical Association urge State legislatures and registration officials to study carefully the recommendations made in this publication and wherever possible to put them into effect by enactment into law or by administrative regulation. It especially urges that the right of inspection of birth records be restricted to the registrant, if of legal age; his parents, guardian, or their legal representative; health and official agencies on the approval of the official custodian of vital records or on court order.

Indian Conference on Social Work to Meet

Observers from 22 Asian countries are expected to attend the third annual session of the Indian Conference of Social Work, to be held in Delhi during the last week of December this year. Among the subjects to be discussed by the conference are family, child, and youth welfare.

There will be a symposium on "Social work abroad," in which representatives from the United States, the United Kingdom, the U. S. S. R., Australia, Sweden, Switzerland, and Czechoslovakia will participate.

To Prepare Medical Social Workers for Positions in Public-Health Agencies

Under grants from the Children's Bureau, Federal Security Agency, a special sequence of courses and field work has been developed in two training centers to prepare medical social workers for positions as consultants in public-health agencies.

These training centers have been established in response to the need for additional, and better-prepared, medical-social consultants in the expanding health and medical-care programs under public auspices.

This type of training is being offered by: (1) The University of Chicago School of Social Service Administration, in cooperation with the University of Illinois, Division of Services for Crippled Children, and (2) Tulane University School of Social Work, in cooperation with the Louisiana State Department of Health. Further particulars can be obtained by writing to the Dean, School of Social Service Administration, University of Chicago, Chicago 37, Ill.; or to the Secretary of Admissions, School of Social Work, Tulane University, New Orleans, La.

A third such training center is being developed in Boston by the Massachusetts State Health Department and three schools of social work in Boston.

• FOR YOUR BOOKSHELF

PARENT AND CHILD, by Catherine Mackenzie. William Sloane Associates, New York, 1949. 341 pp. $2.95.

It is an unusual occurrence when the contents of a newspaper column or page deserve collection in book form. Catherine Mackenzie's page, "Parent and Child," in the Sunday magazine section of the New York Times, more often than not has such lasting value. To Miss Mackenzie, then, an accolade for sifting out, from the meetings, interviews, and reams of material that come her way, the kind of findings and observations that stand the test of time. Many of these have been collected into this new book.

Under such headings as Family living, Emotional problems, Work and play, Delinquency, and Health, the book, titled Parent and Child, gathers together thoughtful comments and suggestions of much more than ephemeral value.

Among the journalists writing on the care and development of children, Miss Mackenzie holds a unique position. The fact that she is not a professional worker in the child-development field enables her to write with a perspective that a person emotionally embroiled in the very thick of children's problems cannot always have. Her insight and good judgment, her meticulous care in reporting, her sense of the timely, all commend the selections in this book to all who have children, or who work with or for children.

Marion L. Faegre

HISTORY OF NURSE-MIDWIFERY IN THE UNITED STATES, by Sister M. Theophane Shoemaker. A dissertation submitted to the Faculty of the School of Nursing Education of the Catholic University of America in partial fulfillment of the requirements for the degree of master of science. Catholic University of America Press, Washington, D. C. 1947. 64 pp. $1.25.

Nurse-midwifery as a clinical nursing specialty in the United States came into being only within the past 25 years. Because the term midwife in the United States suggests a type of care given to maternity patients by untrained women, confusion has arisen in the minds of professional and lay people as to the qualifications, preparation, and functions of the nurse-midwife.

Sister Theophane Shoemaker, Director of the Santa Fe Catholic Maternity Institute School of Nurse Midwifery, Santa Fe, N. Mex., in this history has attempted to investigate the circumstances that led to the introduction of nurse-midwifery in the United States, to trace its development from its inception, and to discover the factors that have exercised the greatest influence in its development. This is the first study of this kind to be published.

The author has pieced together from the meager published articles on nurse-midwifery, from bulletins and reports from the existing nurse-midwifery schools in the United States, from personal interviews, and from correspondence with nurse-midwives, an account of the development of this clinical nursing specialty.

She has described the existing schools of nurse-midwifery, as well as those which have been closed, the activities in which nurse-midwives are engaged, licensure of midwives, and opportunities open for nurses prepared in this specialty.

In some instances the report is not as complete as one would wish, but it gives a good over-all view of the subject. A good bibliography is included.

Ruth Doran, R. N.

• CALENDAR

Oct. 16—Children's Day. Sponsored by the American Parents Committee and Parents' Magazine.

Oct. 23–28—National Council of Jewish Women. Nineteenth triennial convention. Baltimore, Md.

Oct. 24—United Nations Day.

Oct. 24–28—American Public Health Association. Seventy-seventh annual meeting. New York, N. Y.

Oct. 24–28—Thirty-seventh National Safety Congress and Exposition. Chicago, Ill.

Oct. 31–Nov. 1—Children's Bureau Advisory Committee on Crippled Children's Statistics. Washington, D. C.

Nov. 2–5—Second Pan American Congress on Pediatrics. Mexico City, Mexico.

Nov. 6–12—American Education Week. Twenty-ninth annual observance. Sponsored jointly by the National Education Association, the American Legion, the United States Office of Education, and the National Congress of Parents and Teachers. Information from the National Education Association, 1201 Sixteenth Street NW., Washington 6, D. C.

Nov. 7–10—National Society for Crippled Children and Adults. Annual convention. New York, N. Y.

Nov. 13–19—Book week. Annual observance. Information from Children's Book Council, 62 West Forty-fifth Street, New York 19, N. Y.

Nov. 14–17—American Academy of Pediatrics. Annual meeting. San Francisco, Calif.

Nov. 15–18—Girl Scouts of the United States of America. National convention. Milwaukee, Wis.

Nov. 15–18—National Council of Negro Women. Annual convention. Washington, D. C. (This date was previously announced as Nov. 17–20, but was changed on account of unforeseen circumstances.)

Nov. 16–18—School Food Service Association. Annual meeting. Washington, D. C.

Nov. 19—National Kids' Day. Sponsored by the National Kids' Day Foundation, Inc., and Kiwanis International. Information from O. E. Peterson, Secretary, Kiwanis International, 520 North Michigan Avenue, Chicago 11, Ill.

Illustrations:

October cover—Supervised cooking in a Los Angeles nursery school. Wide World photograph.

Pages 58 and 59, courtesy of the author, Dr. Hallie Isabel Morgan.

UNITED NATIONS DAY, 1949

BY THE PRESIDENT OF THE UNITED STATES OF AMERICA

A Proclamation

WHEREAS throughout the march of civilization mankind has yearned for security, justice, and lasting peace; and

WHEREAS the Charter of the United Nations, which embodies these aspirations, has instilled in the peoples of the world a renewed faith that by cooperative international effort and perseverance they may succeed in effectuating these ideals among men; and

WHEREAS October 24, 1949, marks the completion of the fourth year in which the United Nations has been a living force for solving the major problems involved in transforming a shattered world into a better habitation for the human race; and

WHEREAS the General Assembly of the United Nations, by its unanimous resolution of October 31, 1947, established October 24, the anniversary of the coming into force of the Charter of the United Nations, as "United Nations Day," to be devoted each year to acquainting all peoples with the aims and achievements of the United Nations and to gaining their support for the work of this organization:

NOW, THEREFORE, I, HARRY S. TRUMAN, President of the United States of America, do hereby urge the people of the United States to observe October 24, 1949, as United Nations Day with ceremonies designed to affirm our faith in the objectives of the United Nations, our appreciation of its accomplishments, and our resolve to give active support to its principles.

I also call upon the officials of the Federal Government, the Governors of States, the mayors of cities, and other public officials, as well as civic, educational, and religious organizations; upon the agencies of the press, radio, and other media of information; and upon individual citizens to cooperate fully in public programs dedicated to strengthening our participation in the work of the United Nations.

IN WITNESS WHEREOF, I have hereunto set my hand and caused the Seal of the United States of America to be affixed.

DONE at the City of Washington this 25th day of August in the year of our Lord nineteen hundred and forty-nine, and of the Independence of the United States of America the one hundred and seventy-fourth.

Harry Truman

By the President:

Dean Acheson

Secretary of State.

VOL. 14, No. 4 October 1949

the CHILD

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Managing Editor Sarah L. Doran
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Arthur J. Altmeyer, Commissioner

CHILDREN'S BUREAU
Katharine F. Lenroot, Chief

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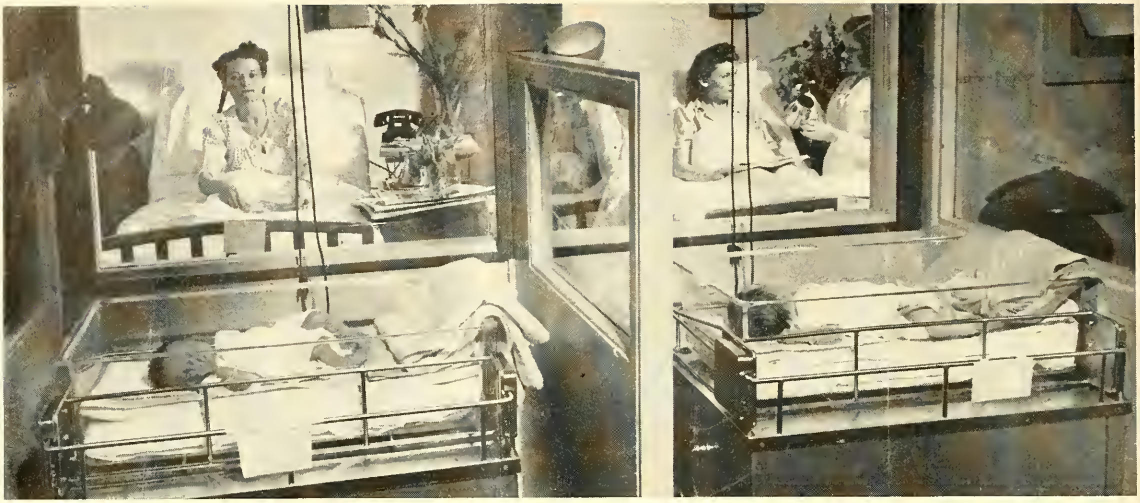
the CHILD



Under many hospital rooming-in plans, when a newborn baby is not actually with his mother she can watch him through a glass window.

U. S. SUPERINTENDENT OF DOCUMENTS

DEC 17 1949

I ROOMED IN WITH MY NEW BABY

BARBARA S. BACKUS

THERE WERE no happier people in the world than my husband and I when we found out that a baby was on its way! We were young, we were in love, and nothing could add more to that than a child. After the first flush of enthusiasm settled down into a steady, quietly expectant happiness, we began to make the usual plans—a layette, a home with enough room for our growing family, a hospital, et cetera.

What of the future?

And then, of course, I began to worry. I'd never been around a small baby. Would I know how to take care of one? Would I know how to be a good mother and yet a good wife, or would I become bogged down in the bewildering routines of new motherhood?

The joy and anxiety would alternate with a small, nagging fear. Because I knew that the homecoming with a new baby wasn't going to be easy.

We were members of that large postwar group, student veterans and their wives. And while my husband taught part time to supplement his GI allotment, there wouldn't be enough money to have a nurse for those first few difficult weeks at home. That meant taking our new arrival home—11 miles out in the country, the only housing we'd been able to find in the college-crammed town—to a house poorly designed for winter living, far from help and neighbors. And, frankly, I was scared.

But pregnancy was a common event in student circles, and from young wives who had been in New Haven longer than I had, I began to hear hopeful stories. Grace-New Haven Community Hospital had a new and progressive plan, called rooming-in. There, the newborn baby and mother were together from the moment of birth. No seeing your baby only at feeding time, no frustrated fathers peering through glass at their babies, no uncomfortable feeling of suddenly finding yourself ready to go home, with a helpless little THING in your arms that you scarcely knew or had handled.

Others liked it

This sounded made to order for me. The enthusiasm of the mothers who had tried the new plan, the prospect of getting to know my baby before I left the security of the hospital, and the idea of being in on a new project, all intrigued me. Again, in company with other young university wives, I was getting my prenatal care at the Grace-New Haven Community Hospital clinic, and there I made application for the rooming-in unit.

Looking forward

Since the rooming-in unit works closely with the clinic staff, I was assured of a bed in the unit if one was available when my baby chose to arrive. Although there are now two rooming-in units of four beds each, at that time there was only one unit. And as babies cannot be timed with the accuracy of a railroad schedule, no more definite arrangement was possible. But at the worst it meant waiting in a regular room a few days and then going into the unit; so I was happy.

At every visit to the clinic, thereafter, I saw one of the pediatricians attached to the rooming-in unit. They went into my attitude carefully, made sure of my interest in breast-feeding my baby, answered all my questions, and succeeded in making me so excited about my pregnancy that I could scarcely wait to have my child!

And the baby is born

Our daughter was born on December 6, and luck was with me, for a bed was available in the rooming-in unit the next day. It was one of the most delightful experiences of my life.

The hospital had taken a large solarium as the basis for the rooming-in unit. This room had been divided into two sections, one containing four cubicles for four mothers and their babies, the other containing the nurse's office and a small nursery. Each cubicle had a bed, a bassinet, a bedside table, an over-bed table, and a comfortable chair. All essentials for taking care of the baby were in a metal container on the over-bed table, within easy reach of the mother—diapers, bands, shirts, cotton, oil, thermometer, and so forth.

These cubicles were so arranged that each mother, by simply drawing a curtain, could change her cubicle into a private room. Yet when the curtains were not drawn, the unit became one large, cheery room, where the four mothers could visit chattily with one another and watch the progress of four different babies. There were gay chintz drapes at the windows and a general atmosphere of cheer and contentment.

A new mother is pretty tired and finds herself quite content, the first few days, simply to lie and relax, and feel her strength flow back. So perhaps you would think that to have your newborn child with you would be tiring and difficult. But a newborn child is finding his advent into the world quite a tiring experience, too, and is pretty apt to sleep from feeding to feeding. Not only that, but since he is at his mother's bedside, he can be fed *as soon as* he is hungry; so there are no crying babies in a rooming-in unit—just four happy, sleepy little mortals.

It was utter joy to me to lie on my elbow, for hours at a time, admiring my sleeping daughter. I could watch the delicate veins in her eyelids, the little quivers of her mouth, the translucent pinkness of her small, curled fists. I could hold her, love her, touch her. And this did not tire me nor distract me from the urgent business of getting strong, but rather seemed to make the strength come flooding back to me. It made me want to be strong enough to take care of my daughter.

A hospital with a rooming-in unit provides the new mother with as much help as she needs.

I learn from the nurses

There was one nurse on duty for the four mothers, and she was helped by several student nurses. This meant we had excellent care at all times. The first few days, a nurse took care of the baby, right at my bedside, where I could watch. And at night the baby was wheeled into the small nursery, where from my bed I could look through a window and see her and yet be assured of an unbroken sleep. Each day I took over as much care of my small daughter as I felt strong enough and competent enough to handle. This was *never* compulsory. The nurse would have done it all, if I had desired. But it doesn't seem possible to me, in such a situation, that any mother would act differently. When your baby is beside you, to be loved and cared for, it is the most natural thing in the world to *want* to care for your own baby yourself. Since taking over the care of the baby was done slowly and progressively, my confidence grew accordingly. A helping hand was always near to steady my first shaky attempts at changing and bathing. Soon I was handling Mary Elizabeth with all the ease and aplomb (I hoped!) of an experienced mother. At least, the baby seemed happy and comfortable.

Four personalities to watch

Living so closely with my own baby, I also lived close to three other babies, which gave me an unparalleled opportunity to watch their differing developments and to learn that babies don't react like so many robots to given stimuli, but are quite complete little individuals. This memory was to be a great help later on, when Mary Elizabeth didn't do things at exactly the same speed, or in the same way, as was outlined in the baby book!

(*Continued on page 77*)

PSYCHOLOGIST CAN HELP IN PLANNING FOR BABY'S ADOPTION

HELEN ROME MARSH
Chief Psychologist, the Cleveland Guidance Center

I LIKE TO THINK that most workers in the field of adoption are accustomed by now to having a psychologist evaluate the development of a child 6 months of age or older before placing him for adoption.

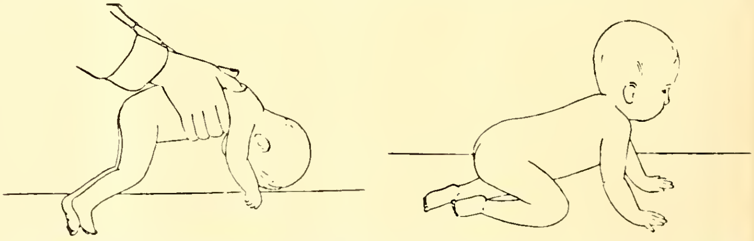
I say "I like to think" because I'm not really sure that psychological services are as widely used in planning for adoption as they might be. Very definitely, by the time a baby is 6 months old, we are able to give him tests and to arrive at objective conclusions about his general development in comparison with other babies of his age. Also, we can arrive at subjective conclusions about his personality development, and, after fitting both types of conclusions together, we can make recommendations concerning his adoption.

When we psychologists examine the child, we evaluate his response in relation to a norm, asking, "How does this child compare with the norm for children of like age and sex? We can answer this because we know that the norm we are using is the result of observation and measurement of thousands of babies of the same age and sex as this one.

To find the answer we must observe the child's actions in a standard situation, rather than relying on the report of the mother or anyone else. For even though reports by the mother, or the foster mother, or the social worker may assist the psychologist in interpreting the results of the tests, he relies for his information about the child's responses only on what he sees himself.

This may sound rather cold and detached. But although there may be an occasional baby whose development is underrated because, in a test situation, he refuses even to approach a rubber doll, we know that the errors of this type are fewer than they would be if the psychologist depended on the notoriously inexact report of the average devoted mother. This attitude on the part of the psychologist is especially necessary when dealing with very young babies, as there is less variety in the test situations that are presented to such a baby.

We should not, surely, talk about appraisal of the development of children without mentioning the best-known testing devices and observational scales. A great many people, especially those working in the children's field, are familiar with the tremendous life work of Dr. Gesell, and the contributions that he has made to our understanding of the growth process. His developmental schedules have been used, in one form or another, for a quarter of a century, and yearly he has added to our knowledge in the field of measuring the maturity of children.



Note difference in posture control between this 4-week-old (left) and the 40-week-old.

Dr. Gesell's developmental schedule permits us to observe and classify the behavior of children from the age of 4 weeks to 3 years. He suggests the use of the developmental quotient, or D. Q., which shows what percentage of normal development is present at any age within the limits mentioned, and which is quite reminiscent of the well-known intelligence quotient. In fact, because it seems so like the I. Q., many clinicians prefer not to obtain a baby's developmental quotient, choosing rather to give their evaluation of his development in more descriptive and comparative terms.

Dr. Gesell's technique also permits comparison of the child's development in four separate areas, which he feels are the major ones. They are the adaptive, motor, language, and personal-social behavior areas. Each of these is believed to be separate from, and parallel to, the others, and a D. Q. can be obtained concerning each one by itself. Dr. Gesell feels that the predictive value of these D. Q.'s is great, though not all other investigators agree. Some of this variation in opinion is certainly due to differences between the skills measured in infancy and those measured 5 or more years later, when tests utilize verbal skills more. We find that the older the child is, the more the tests attempt to measure abstract ability, a type of ability which is obviously quite different

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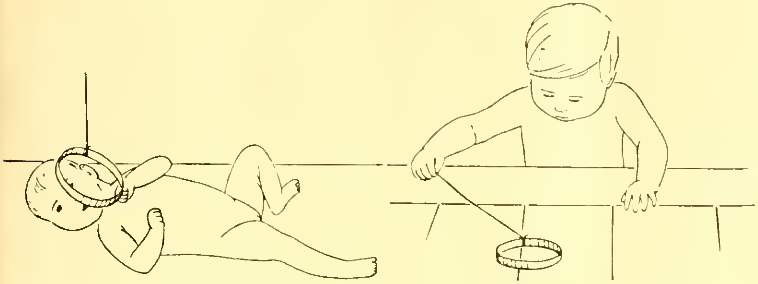
This paper was given at the seventy-sixth annual meeting of the National Conference of Social Work, at Cleveland, Ohio. The drawings, of babies of differeent ages responding to typical test situations, are reproduced, with permission, from Developmental Diagnosis, by Arnold Gesell, M. D. and Catherine S. Amatruda, M. D. (2d edition, 1947. Paul B. Hoeber, Inc., New York.)

from those measured by the earlier tests of development. For this reason the experienced clinician will, in addition to evaluating the whole developmental picture, take particular pains in examining those areas of early development which seem to have the highest correlation with what we consider measures of "intelligence" at later ages.

Most of these remarks have been about Dr. Gesell's tests, and I should mention the work of others whose contributions to the field of infant testing have also been great.

First, there is Dr. Psyche Cattell's technique of measuring infant intelligence, a method which gives us an I. Q. and which measures infant development from 3 months to 30 months. This scale has the distinct advantage of being a downward extension of Form L of the Stanford-Binet scales, and its upper levels include much of the material that occurs in the Stanford-Binet. Therefore, it is possible when testing older children to go directly from the Cattell into the Stanford-Binet. With younger children, however, the material is very similar to, and in many cases identical with, the Gesell material. The prime difference between the Gesell and the Cattell tests is that the Gesell breaks down its results into the four categories I have mentioned, and the Cattell makes no such provision. Historically, there are other infant-development schedules which can be mentioned: the Kuhlmann, Bühler, Brush, and others. Also new ones are in the making now, but the Gesell and the Cattell are probably the most widely used at present.



These two babies (4 weeks and 28 weeks of age) behave very differently with a test ring.

I wish I could say that it is possible to predict, with great exactitude, the intelligence level of a 1-month-old infant and guarantee that there will be no change in it from then till senile decay sets in. This isn't the case, though, and our accuracy in predicting intelligence when a baby is a month old is less than it will be when he is 6 months of age or older. At 1 month or less the child is not evidencing enough activity or response to the environment for us to be able to sample as many of his potential abilities as we will some months later. And therefore what he does show has greater weight in the estimate that we make.

This is, obviously, one of the reasons why so many psychologists do not like to estimate the stage of development of a baby at such an early age, and from the point of view of exact prediction of intellectual capacity, I am in agreement with them.

For early placement

Nevertheless, I think we have to be realistic and practical, and, while it would be nice to give a series of tests covering several years—tests that we could depend on when making our estimate of mental capacity, we also know all too well the dangers and disadvantages of delaying so long the permanent placement of the child. So if we are going to try to do away with long delay and place the child very early, we are going to have to sacrifice some of our certainty about his abilities. Parenthetically I may say here that this remark holds true for the immediate present only, for with more experience with the placement of very young babies we shall be able to develop more ways of making our judgments. These will serve to make us more certain in our estimates, but that is something for the future.

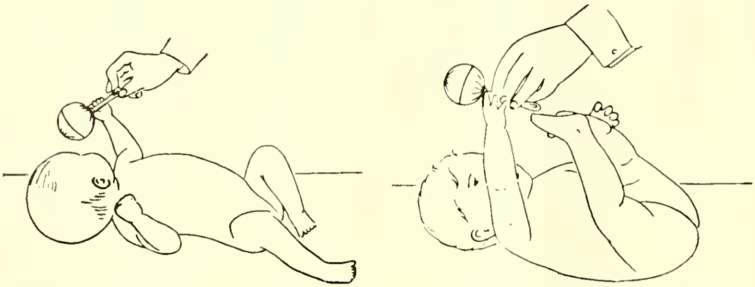
For the present we are concerned with using the skills and knowledge we already have. So even if we are not positive about how far a specific child is going to go in school and how brilliant he will be, it is better to make our estimates of his performance and general responsiveness at a very early age than to delay his placement half a year. I am referring here particularly to the personality aspects of the baby's development.

Home affects baby's development

I am sure that all social workers are well aware of the effect of a foster home on a child in his first year. When the placement is successful, the baby goes into a home where he gets a lot of warmth and security and attention, necessary conditions for normal development. When the foster home offers the child less favorable conditions, his development suffers. And if a baby is in an institution, even a very good one, you know that he is going to get less of the necessary warmth and security and attention than we want him to have; as a result psychologists routinely expect a baby in an institution to rate lower than his true potential level as it is revealed when the child is tested again after leaving the institution and being placed in a good adoptive home or foster-home.

And so when we examine a baby a month or so old, who has been placed in a temporary home, we may be getting results that are statistically less valid than if that baby were in his own home. A baby in his own home will be responding to the same environmental influences at a year as at a month, and presumably will continue to react to the same general ones for years to come, whereas a baby in temporary placement is responding to influences that will not necessarily remain with him. Thus when a very young baby is tested he has the advantage of being less affected by a poor foster-home or institutional treatment than an older one in a similar environment simply because the younger one has not been exposed to that unfavorable influence so long.

This may sound as though I believe that any very young baby who tests within average limits should be placed immediately in an adoptive home. I do not mean to imply this at all, although I presume that all of us who are interested in the earliest possible placement of babies realize the great importance to both the adoptive parents and the baby of bringing them together as early as possible; yet none of us would wish to place a baby for adoption if there is any question at all that might endanger the maximum protection that we want both the adoptive parents and the child to have.

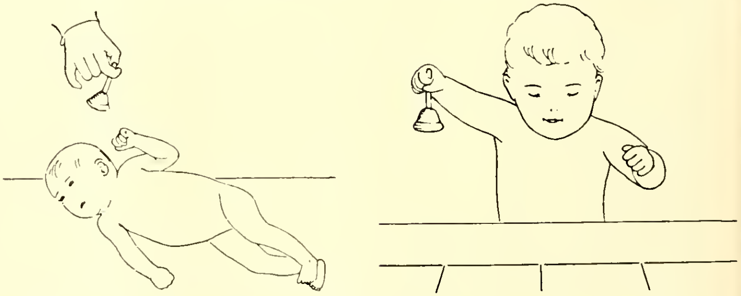


A rattle gets scant response from this 4-week-old (left); the 40-week-old shakes it.

For this reason, I want to stress as much as I can my conviction that the younger the child, the more important the social history and background material are in relation to the psychological observations and testing.

Family background plus test results

A young baby who "tests average" and appears entirely normal in every way at 3 months may well be exactly that, and may remain within normal limits for years. But if the background indicates that there is some question about the intellectual normality of the parents—either one or both—then the weight of the evidence would seem to lie in the social material rather than in the test. In such a case, to my way of thinking, it would be wiser not to attempt the permanent placement when the baby is so young, but instead to initiate a series of tests at frequent intervals over the next several months, in order to check on the first test and to get an estimate of the child's rate of development. Here, although this is an idea that may be questioned by some workers in the field of adoption, I cannot but feel that there might be some advantage in having serial tests made during the probationary period on babies who are placed very young, to study the rate of their development. This, obviously, would be something which would need to be handled very carefully, but just as a baby is taken to the pediatrician at regular intervals for physical check-ups so he could be brought regularly to the psychologist.



This 4-week-old (left) heeds the sound of a bell, but the 40-week-old rings it himself.

The idea would not be to threaten adoptive parents with the possibility of removal of the child if he did not keep up his original rate, but would be presented as a special help in showing parents the areas in which their youngster is developing most rapidly, and those in which some aid or extra stimulation is needed. This is offered as a speculation, not as a suggestion or recommendation, about the service we might some day be able to offer not only to parents who are adopting a child, but also to natural fathers and mothers.

To take the case of the infant with an excellent background, who tests in the retarded range, I would again hesitate to place him early, but because of his good family history I would perhaps be less skeptical than with an infant who tests average, but who has a questionable background. Again, I would think it wiser to check again, but the degree of retardation would be of prime importance here; the greater his retardation, the less hope there would be that a recheck would produce a change upward. We all feel, I know, that we owe it to the adoptive parents and the child to start them off together as favorably as possible. If this means evaluating the child's development and potentialities more than once, I am sure that it is something we should consider seriously.

Of course, the child who is developing at an accelerated rate, and has an excellent background to boot, is one we probably won't have to worry about; and the one who is markedly slow, with a family history that is highly questionable or unknown is one we probably wouldn't consider for early adoption anyhow.

It is, to my mind, in the cases where question exists, either concerning the available information about the parents or concerning the child himself, that the psychologist and the adoption worker can most effectively put their heads together and consider what they have.

There is another area where I think that the psychologist has much to offer—the realm of personality evaluation. It is to be expected, of course, that the agency will have a good idea of what sort of people the prospective parents are—but it is not nearly so sure a thing when it comes to the personality of the baby.

The younger the child the less there is to observe, but even the little baby gives indications of his personality. I think we would all agree that much of his future personality will be a reflection of what is around him and what type of home he is in. Yet there are limitations to the effects that environment will have. For the trained eye, it is not impossible to detect the phlegmatic child, the outgoing one, the happy one, the easily affected one.

I realize that in many social agencies this estimating of the child's personal qualities is part of the social worker's duty, yet in others it is not emphasized. I suggest that it is an area wherein psychological observation of the child in the testing situation can bring forth material of value, which can be coordinated into the plan as a whole.

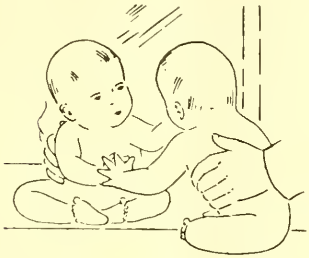
Testing is part of adoption plan

Therefore let me say, in summary, that I feel that the psychologist with his skills has a great deal to offer in the field of early adoptive placement. I do not say that the tests and techniques which we have now are so perfect that they can be used with nary a question or qualification on anyone's part, but I do say that the background knowledge and ability of the trained child psychologist can contribute something which, correlated with what our tests and observational schedules bring us, tells us more about the potentialities and probable traits of the young infant than can be obtained by less objective methods. In addition, the training and curiosity of the psychologist should be able to bring forth material which, in a few years, should make the task of evaluating the youngster easier and the results more valid.

I have suggested that when an infant has a doubtful background or personal ratings, a series of tests might be very desirable. I have done this in the face of what may well be considerable objection on the part of the adoption worker, for various reasons that I can see carry weight. Nevertheless, since I am speaking as a psychologist, with a psychologist's point of view, I would like to elaborate again on my idea here. Mainly, I should say that I am in total agreement with the idea of placing the child for adoption as early as possible, because of the emotional advantages to be gained from living in the permanent home from a very early age—and I mean the emotional advantage both to the child and to the parents. Certainly the main wish of all of us is to have the situation in the adoptive home as similar to that in the home of the natural parents as possible.

Hope to prevent misplacement

Yet at the same time, I have reservations that I am sure many of you share—reservations that are concerned with the possibility of misplacement of a child in a home. Naturally, one would hope that the selected adoptive parents would themselves have such good personal adjustment that if they were to find themselves the parents of a retarded child it would not jeopardize the unity of the family. We all would hope such a situation would not arise, but it is in hope of preventing such situations that I feel that serial testing of questionable children is needed. Even though some question about them may prevent placement at 4 or 5 months, serial examination may have them ready for adoption by 10 or 12 months; whereas under the old method of waiting, these very children might be having their first evaluations at 1 year or thereabouts. In the long run, serial tests should still help in getting these babies into permanent homes earlier than once was the case, though perhaps not as early as some workers might like to place them.



At 28 weeks of age, this baby looks in the mirror, smiles, makes sounds, and pats the glass.

Again I say our tests are not infallible—would that they were! But very few things are, and even though we ourselves state that our very early test levels are not as unfailingly accurate as we might like, nevertheless we feel that they are successful in ruling out the baby who markedly deviates from the normal and in pointing out the one who in some ways is not developing as rapidly as in others. Just as the adoption worker seeks to rule out as adoptive parents those men and women who are not mature and flexible and those who expect a child to fulfill unsatisfied neurotic needs of their own, so we should like to have the opportunity of helping to rule out, at least for very early placement, those babies about whom we feel there is some room for doubt on the basis of our evaluations and observations.

We want, on the other hand, to be able to point to other babies, and to be able to tell the adoption worker that we feel these are good adoptive bets, young as they are. Therefore, what I am saying here is that the psychologist very definitely has something to contribute to the planning of early placements for adoption. We can show you those children whose development varies from the expected. We can show you those children whose development is accelerated or retarded, whether in toto or in specific areas. We can tell you something about the personalities of babies, and can help you, by telling you all these things, to match babies and parents with more objective material to aid you than before.

The trend to early adoptive placements is comparatively recent, and such placement should be a cooperative enterprise by all the workers concerned—all who have something to contribute. We psychologists are eager to tell you what we can offer, and at the same time we are equally frank in telling you our limitations. It is only through an understanding of what each profession can add to the whole that we can pool our efforts successfully and arrive at techniques and methods that will ultimately yield the most satisfactory results for the natural parents, the adoptive parents, and the baby himself.

Reprints in about 4 weeks

NORWAY IMPROVES LAWS PROTECTING MOTHERS AND CHILDREN

ARNFINN GULDVOG

Norwegian Embassy, Washington, D. C.

Although the Constitution of Norway contains no provisions regarding health or welfare, the care of mothers and children has gradually gained a recognized position among the social measures taken by the Government. In comparison with the most advanced countries, however, Norway is still lagging behind in this field.

The importance of securing the best possible conditions for expectant mothers and for children is now meeting with increasing recognition, and this is reflected in legislative, administrative, and other measures for their protection.

Our legislation for the protection of mother and child includes laws providing for health services to pregnant women and to women with children; also for assistance to mother and child, as well as for welfare services in general. Some of these provisions are discussed here. (Health services for children of school age were described by Anna Kalet Smith in *The Child* for January 1948.—Ed.)

Since 70 percent of the people of Norway contribute to a sickness insurance fund, established under an act passed in 1930, approximately 70 percent of women who have babies will thus get their expenses for maternity care refunded, including hospitalization. If the woman is a wage earner and as such is herself contributing to the sickness insurance fund, she receives an additional lying-in allowance, corresponding to 6 weeks' sick-benefit.

A woman who is not contributing to a sickness insurance fund, either directly or as the wife of a contributor, is not entitled to have her confinement expenses refunded. However, if a mother is unmarried, widowed, or deserted, she may, under the provisions of an act of 1915, receive economic assistance for 6 months before confinement, and not more than 6 months afterward. (This assistance is not considered poor-relief.) The allowance is paid by the local authorities, its size varying according to the financial condition of the township or municipality concerned. The money paid for this purpose by the local authorities in the 34 years since the act was passed, does not, however, amount to any large sum.

In every quarter of the world, children are a nation's greatest asset, and Norway is showing recognition of this by enacting laws for the protection of the health of mother and child.

As part of the general relief provisions of laws passed half a century ago, under which persons without sufficient means of support receive a subsistence allowance from the Government, maternity care is given by the district midwife at public expense.

In a few municipalities—for instance in Oslo—assistance in the form of mothers' allowances is given to any woman who is the sole support of dependent children staying at home. This assistance is in the form of a yearly allowance and is granted only if the income of the mother and the child for whom the allowance is granted does not exceed a specified amount. In Oslo, such a dependent child also receives free medical aid, medicines, and hospital treatment.

Assistance of a more general character for the benefit of children is provided by an act of 1946. Under this act, any resident of Norway who supports more than one child under 16 is entitled to an annual allowance for each such child, beginning with the second one.

This allowance takes no account of the breadwinner's financial condition, and is paid whether the child is born in or out of wedlock, or is a foster-child, a stepchild, or an adopted child. But at least one of the parents of the child must be a Norwegian subject. This allowance system now provides benefits for some 370,000 children.

Under a law of 1936, a working woman who is pregnant is entitled to leave of absence from her employment during the last 6 weeks before the anticipated date of her confinement and the first 6 weeks afterward. She may not be discharged for absence from work caused by her confinement.

The father of a child born out of wedlock is required by law to pay a maintenance allowance. Besides, a child born out of wedlock is entitled—irrespective of the wish of the father—to use the father's family name, and, under the law, inherits from him in the same way as do his legitimate children.

A number of measures are prescribed in a law of 1917 for the protection of children to be adopted. The Provincial Governor who issues the adoption order must in each individual case decide whether or not the adoption will promote the welfare of the child.

No one who has attained the age of 12 years can be adopted without his own consent, and for anyone under 21 years of age the consent of guardian or parents is necessary.

With certain exceptions, an adopted child has the same legal status in relation to his parents by adoption as do the adoptive parents' own children.

Furthermore, Norwegian citizens may not adopt or be adopted abroad except with the permission of the Ministry of Justice.

Under a guardianship act (1927), every minor in Norway must have a guardian—either his own father or mother, or an adoptive parent, or an appointed guardian. The act details provisions of the personal qualifications required of a guardian.

As a member of the United Nations and of the specialized agencies of the United Nations, Norway has actively participated in framing and adopting resolutions concerning family welfare. We hope that these international steps will contribute to the development and improvement of our own activities in the field of social welfare.

Reprints in about 4 weeks

TO SYNCHRONIZE THE TRAINING-SCHOOL PROGRAM WITH LIFE IN THE COMMUNITY

RICHARD CLENDENEN

Consultant on Training Schools, Social Service Division, Children's Bureau

A TRAINING-SCHOOL program is planned to provide for a temporary period of treatment and training for children who are in need of protective group care. The child does not stay in the training school indefinitely, nor do the personal relationships formed there replace family ties. The child may be in the institution for a year, even 2 or 3 years, but sooner or later he exchanges his life in the protective environment of the institution for one in the outside community and resumes some form of family living. The focus of the training-school program, therefore, must be upon training the child to live in the larger community outside the school, not upon training the child to fit into an institutional program.

School must keep up with community

The way of life in the larger community is not static, but constantly changing.

During the past 20, 15, or even 10 years life has changed a great deal for many of us. Job opportunities and working conditions have shifted and changed. The pattern of family living has somewhat altered.

As a people we have become more mobile, are subjected to wider and more varied influences, and are living under greater pressures.

We have become more conscious of general social conditions both in this country and abroad, and more aware of their impact upon our lives.

We have lost some of the basic security which we enjoyed when family groups were more cohesive and other continents were still separated from us by very wide seas. Some of the added pressures, unrest, and insecurity that grip such a large part of the world are communicated to our children and youth. This does not necessarily mean that as child-welfare workers we shall be called upon to care for more children. It does mean that the children will bring to us somewhat altered attitudes, reactions, and needs, that we must prepare children for a somewhat different way of life, and that we need continually to reshape our programs if we are to provide realistic preparation and training for life in a larger society.

In addition to living in a dynamic, changing society, we are working in a rapidly developing specialized field—providing residential treatment for children adjudged delinquent. With the assistance of case work, group work, education, psychiatry, medicine, and other disciplines, we are gaining in our understanding of human behavior and of the values, limitations, and functions of residential treatment. As a result, we are discovering new and improved treatment methods.

The problem, then, of keeping a training-school program synchronized with life in the community is twofold. First, we must keep the program in tune with the times, geared to our constantly changing way of life. Secondly, we must adopt into the program new methods based upon our rapidly developing understanding of human behavior and the function of residential treatment in the training school.

In preparing a paper on synchronizing a functional training-school program with community living, it seemed to me that I might attempt to sum up some of the developments and trends in the training-school field. Not only is this a natural approach for a worker representing a Federal agency with Nation-wide contacts, but it has the added value of dealing with developments that

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Given at the seventy-fifth annual meeting of the National Conference of Social Work and included in the proceedings of the National Association of Training Schools.

are part and parcel of functioning programs, rather than with purely theoretical considerations.

Such an approach logically raises a question: Are there significant evidences of growth and development in this field in the direction of improving the quality of training we are providing for children? Or is the field relatively static and inactive?

The Children's Bureau has child-welfare representatives in each of the regional Federal Security Agency offices throughout the United States, who visit many training schools and have numerous other contacts with child-welfare programs in the various States. Our regional representatives have reported many evidences of growth and development in the programs of training schools in this country.

For more contact with outside world

Some of these developments are resulting in better synchronization of training-school programs and community living. Within the scope of this paper I can touch upon only a few examples to illustrate this trend.

Some of the more important developments can be summarized under two general headings: (1) Those that relate the training-school program more directly to the larger community, and (2) new or improved techniques that implement the content of the training-school program more effectively.

Many times during the past few years training schools have been attacked upon the grounds that they are "isolated"—isolated from the kind of stimulation that would keep the program varied, challenging, and progressive, and isolated from the outside services and facilities that would enrich and extend the program. We are all aware of the enervating effects of such conditions. An institution makes such demands upon its administrators and its staff that its program tends to be limited to its own facilities, and its personnel are cut off from outside stimulation.

The very positive steps that are being taken in many training schools to break down this pattern of isolation and to make the training school an integral part of the community and the total child-welfare program represent, we believe, the most significant single development leading toward more realistic training programs.

Increasingly, training schools are establishing a freer give-and-take relationship with the larger community in which they are located. They are bringing more outside persons into contact with the program. They are enlarging the opportunities for staff members to make contacts away from the school. They are lending the use of some of their services and facilities to the community and calling upon the community for the use of some of its resources. All of these developments help to synchronize the training-school program with life in the community.

A training school that synchronizes its program with life in the community will not only provide vocational training within the school, but will arrange for on-the-job experience outside.

Volunteers bring in new ideas

Several methods are being used to bring more persons into contact with the program. One of these is the use of volunteer workers. Recognizing the vitality that new persons with fresh ideas bring to many phases of the program, many more volunteers are being used. In many schools volunteers contribute to the recreational program as coaches, group leaders, and handicraft teachers. In other schools they play vital roles in religious programs. In still others they serve as big brothers or big sisters to individual children.

Whatever service volunteers render, the problems involved in their use are much the same. These workers need training for their jobs just as much as other members of the staff do. No phase of the program can be surrendered in its entirety to volunteer personnel. Volunteers need the help and support of the regular staff members who have a closer and more continuing relationship to the children. However, if provided with instruction, careful guidance, and support, volunteer personnel can not only contribute to that portion of the program in which they participate, but they can bring fresh personalities and new ideas to both children and staff members.

Training school a part of the community

Another method used to bring more persons into the program of the school is by developing joint projects and activities with outside agencies and groups.

For example, a State training school for girls located in a southern State helped to sponsor an institute on sex instruction, which was held for members of its staff and the parents belonging to a local PTA. The same school invited girls from a local high school to attend a course that was given for its own girls on personal hygiene and grooming.

In another State a training school for girls operates a library station which serves a total of some 15,000 people. This latter project not only brings many persons into contact with the school, but provides an opportunity for the girls to contribute something worth while to the community.

Enlarging the opportunities of staff members for outside contacts and for participation in activities beyond those involved in the everyday job also brings the school program closer to life in the outside community. In this connection one school enables members of its staff to participate in many board activities and to serve on board committees. Schools which can do so are securing grants for staff members to enable them to continue professional education on a full-time basis in case work, group work, recreation, and dietetics.

A very interesting development in this area is in several recent proposals which have been made for the exchange of training-school staff members as an educational policy. A training school for girls in Canada recently contacted the secretary of the National Association of Training Schools about the possibility of working out such an exchange with a school in this country. An organization representing several training schools in France has contacted the Children's Bureau through the State Department, proposing an exchange of staff members with several training schools in the United States.

A greatly increased use of services and facilities away from the training school relates the program much closer to life in the community and enriches and extends the program of the school. Increasingly, training schools are calling upon the services of related State and local agencies. They are using outside medical and psychiatric clinics, community-service centers, and recreational facilities. Several training schools, both public and private, are sending a number of their children to public schools. The purpose of this development varies, and so does the basis upon which the children are selected for this outside experience.

In one State training school for boys, the selection is made on an individual basis. If the child can benefit by the experience it is offered to him. A private training school for boys has established a cottage or dormitory for a small number of boys in a large city some 20 miles away from the rural setting of the institution. Boys living in this unit attend the public schools. The cottage is used for boys who need a richer academic experience than the institution can provide, and for those who need an intermediate step between leaving the school and returning to their communities, and also for a few who could not continue to attend school if they returned to their own homes.

The greater use of outside resources for vocational training has enlarged and enriched opportunities for such training by providing more realistic working experiences for older boys and girls. The ability of the training school to supplement vocational training instruction by on-the-job experience has long been recognized. However, maintaining sufficient modern equipment is expensive, and competent vocational instructors often are difficult to secure and keep. Consequently an ever-increasing number of training schools are turning to outside resources to secure on-the-job training for older children.

Many schools permit boys and girls who are legally old enough and are able to benefit from such an experience to work in jobs away from the school.

For example, a State training school for boys in the Middle West provides such job training for older boys. The school assumes responsibility for helping the boys find the right job and maintains a close and continuing relationship with the employers. These boys work 4 days each week and devote 1 day to academic courses which are designed for them.

A State training school for girls has established a program under which older girls work in jobs in the community for several weeks prior to leaving the school. This program has several purposes. It gives the girls an opportunity to secure realistic working experiences. The girls gain experience in handling and budgeting money. They are able to earn money to buy the additional clothing they will need when they leave the school and to save enough to carry them over for a week or two following placement. The program also provides a basis for the school to evaluate the girl's ability to manage her own affairs. Here too, the school provides guidance in securing jobs and maintains a close relationship to the employers.

Careful planning necessary

The success of such a program hinges, of course, upon the amount of time and planning the training school devotes to it. If several children are included in the project, the full-time services of one person will be required to maintain a close working relationship between the school and employers. The employers need assistance in planning the sequence of work experiences for the child and in understanding the problems and needs of the child. They must be made to feel a part of the school team.

Of course, all the developments that relate the training-school program more directly to the larger community are accompanied by problems and growing pains. Surface problems in the school may be increased by them. Public understanding and acceptance are difficult to secure and are not easy to maintain. But it is obvious that this is the direction that must be taken if training schools are to offer more realistic training for the children in their care.

In planning a freer give-and-take relationship between the training school and the community, it must be recognized that there are limits to the child's ability to relate to a variety of persons and situations. Exposure beyond these limits will be detrimental, for the child needs a stable way of life and some protection. The value of any development in this field will be determined by the adequacy of the planning, by the careful preparation of the child for the new experience, and by the establishment of constructive community attitudes.

Receiving the new child

In addition to bringing about a closer relation with the community, many schools are sharpening old or introducing new techniques to implement their basic services more effectively. I have been particularly impressed by the increased attention being given to the process of admitting the child to the school and preparing him for this experience. Many of the private training schools insist that the child visit the school before commitment and that he participate in the decision to enter the school. This is highly desirable, but is impossible for many of the State, county, and municipal training schools, which have no control over intake and may even not know that the child is coming to the school before he arrives. Both private and public training schools, however, can prepare the child for the experiences he will have after he arrives.

A large number of the training schools maintain some kind of reception unit. Historically, the primary function of the reception unit was to quarantine the new child from the rest of the children in the school. Here he was given the necessary medical tests, examinations, and inoculations, to insure that he would not infect the other children.

While these medical procedures remain necessary, we now recognize that primary attention during this period must be fixed on the emotional meaning of this new experience. During the first few days the child forms very basic concepts of us and our program. What we do during this time will have a pronounced influence on the effectiveness of all subsequent training. The new child must be received as a troubled individual who needs sympathy and personal attention. He needs also a varied, rich program of activities and of companionship. During this time he is fearful and troubled, and is unable to make satisfactory use of idle or free time, which at a later date he might transform into constructive play.

Whether or not the school maintains a reception unit does not in itself seem important. But how the child is received, how he is made to feel welcome, and the extent to which his rights are considered in planning with him are important.

Several schools employ an interesting group approach to the problems of orientation. Frequently adolescents are not responsive to an individual approach. They are likely to be suspicious of adults and resent the efforts of a staff member to extend much personal attention. For this reason the group approach has great value. Children in a group derive support from one another and help each other to bring out conflicts and problems.

In one State school boys remain in a reception unit for a period of 10 days. During this time they do not attend the school's regular academic or vocational classes but are provided with a very active recreational and handicraft program. Each morning an hour is devoted to a free group discussion with a member of the staff serving as discussion leader.

At one meeting the subject was "fears." Just what are the things a boy is afraid of in coming to a training school? A bit reluctantly at first and then more readily the boys brought out certain fears and conflicts. One small boy, unable to assume responsibility for his own fears, stated that one of his friends was afraid of the "shots" he would get from the doctor. This gave the staff member and the group an opportunity to discuss the subject. Does it hurt when you get shots? Why are you given them? Will they make you sick? How many will you get? During the meeting the group had an opportunity to discuss a wide variety of fears—a much healthier condition than if these were kept bottled up.

The same school has used a group approach to the problems of preparing children for placement from the school. One or two evenings each week during the last 6 or 8 weeks they are in the school, boys attend group discussions led by different staff members. For example, the director of social services meets with them to discuss the kinds of reactions they may encounter in their home communities. The director of vocational education discusses job opportunities, how to apply for a job, and whether a boy should tell the employer that he has been in the training school.

Importance of family recognized

The vital role that the family can play in making our programs more effective is also becoming better appreciated and receiving increased attention.

Just as we have come to recognize that we cannot successfully treat the child in isolation from the larger community, we also recognize that we cannot treat the child as a social entity separate and apart from his family group. The child brings his family and other close personal relationships along with him when he comes to the school, and these continue to exert a strong influence upon him during the time he is there. The reaction of the parents to the child's commitment and their attitude toward the school and its program may reinforce or detract from efforts to help the child. These facts have led many training schools to give much thoughtful consideration to developing constructive parental attitudes and support.

Parents join in program

One State school has developed a program which might be called orientation of parents. Steps in the process include a personal letter or visit to the parents shortly after the child comes to the school, and an interview with the parents by the superintendent during the parents' first visit to the school. The child is encouraged to show his parents over the grounds, introducing them to the other children and staff members. Parents are not sent a form letter or given a list of rigid rules governing visits. Through personal contacts with the staff they are made to feel that they have an important role to play in planning for the child. They are not excluded from the team, but drawn into it. This program has been so successful that the school is able to permit children to leave the grounds freely with visiting parents.

The system of leave now in effect in several public and private training schools helps to keep intact the child's family relationships and to prevent the families from feeling shut out. Some schools are granting periodic vacations; in others children can earn week ends away from the school. A few have combined these plans. Several administrators feel that the introduction of a system of leave has resulted in a more basic change in the children's attitude toward the school than any other single development in the program.

We have been able to mention only a few of the many developments which are resulting in a better synchronization of training programs and life in the community. We have not been able to touch upon many others. We have not discussed the decline of effort to provide vocational training for younger children, or the increased emphasis upon special academic instruction for these children who will reenroll in public schools. We have not touched upon any of the group-therapy projects that are being carried on, nor the increased attention being given staff development. However, all these and many other developments are important not only in themselves but also because they demonstrate growth and movement.

Concurrently with these developments and underlying many of them has been a deepening interest in the democratic processes of group living. Synchronizing the training-school program with life in the community means that it must be synchronized with a democratic way of life. Adolescent boys and girls will soon take their places in society as adult citizens. Training that fails to give them respect for and experience in democratic living fails to provide realistic training for life in our country today. As the democratic way of life has been threatened abroad, our concern for it has increased at home. We are spending more time defining democracy and are more insistent upon democratic procedures.

In training schools this is finding expression in a greater respect for the rights of the individual child, in or out of the training school. There is more interest in methods that permit the child to enter into the decisions, both individual and group, that affect his welfare. In some schools these are taking the form of student government; in others, a more informal use of group meetings. More emphasis is being placed on teaching tolerance, and on providing children more constructive contacts with representatives of other cultural and racial groups.

The problem, then, in keeping a functional training-school program synchronized with life in the community is twofold. First, it involves a continual adjustment to life in a dynamic community. Secondly, it involves putting into practice the procedures and philosophy evolved from our increasing understanding and knowledge. All these developments are directed toward providing better training for the American way of life.

Reprints in about 4 weeks

ROOMING-IN

(*Continued from page 67*)

An additional benefit of the rooming-in arrangement is its refreshing attitude that father is a member of the family, too—not just a bystander, whose acquaintance with his child should consist of his standing pressed against the nursery window, so many minutes each visiting period. My husband was as enthusiastic about rooming-in as I, because it gave him a chance to know his daughter; to hold her; to watch her first reactions to food, to light, to noise. He would hurry in at visiting time, take off his coat, put on a hospital coat, scrub his arms and hands, and then with great tenderness and care lift and hold Mary Elizabeth. He took this opportunity to learn as much about caring for her as possible. He had me demonstrate my new-found talents of diapering and dressing her, watching how I held her to feed her; and he learned how to hold her securely and safely. This paid great dividends when we went home.

Eight days never went faster. There was so much to learn and watch that it was a completely absorbing experience. And then, suddenly, we were ready to go home.

We go home

It was a big step, to leave the security of the hospital, the comfort of a nurse, and constant care. As I look back on it now, I don't know how I would have managed without the preparation I'd had in the rooming-in unit. Instead of going home to the terrifying experience of having sole charge of a strange, tiny baby, I went with the sure, inner knowledge that I knew my baby. I knew she was a definite individual. I knew she was much tougher than she looked and that, with reasonable handling, she wouldn't break. And I'd learned how to handle her.

I knew, too, that nature had given her a time schedule that was essentially her own and that she was teaching me when she wanted to eat, when to sleep, and when to be sociable. Our first adjustment to each other was already behind us, and we were quite ready to continue the fascinating game of living together.

Reprints in about 4 weeks

With an Intent to Understand

One of the things that I have thought about a great deal since I have been working at the nursery school is my need to understand myself better; to be honest about the kind of person I am in working with children.

Each morning as I walk the five cross-town blocks to the nursery school I wonder what the children will be like today—what park we will go to, what activities we will carry out, what problems will come up—and then I think about how I will try to meet each question as it arises, without interfering either with the child's ability to solve his own problem or with the other teachers' relations with the children. And on returning home at night I try to find out just why I did and said the things I did.

How rapidly children change!

Each child has become so different in the past 3 weeks. And there seems so much to learn and understand about each one:

Why do they do the things they do?

Albert hit Willetts squarely in the nose for no apparent reason, and Bunny gave Kenneth two cherished pennies. Edward, day after day, disrupts "quiet hours." Today his cot was placed near the door just as far away from the other children as possible, but he didn't go to sleep—not at first—he picked on the canvas cot with his fingers as though he were playing a banjo—then he put his head under the blanket and coughed and whistled—finally he called me. I sat on the edge of his cot, placed my hand on his shoulder and just listened. In a whisper out came a torrent of words about Gene Autry, Roy Rogers, and their horses; and about a horse that Edward's grandmother down South owned that he would get to ride Christmas. When he finished he turned over and in a few seconds he was asleep. Not a word was spoken by me.

Yes, this was the thing to do today, but what about tomorrow?

Little or big things?

There are also many other things, little things, that I have found out that we can do for children that seem much more important than the big things, or at least the things that we think are big, but the child doesn't. The tone of our voices. Not seeing the many things they do to each other in learning to be a part of the group. Taking just a minute to sit in one of their chairs. To admire a new dress, shirt, or tie—just those little things are of major interest to the child, and to you, because of the pleasure they give him. Sometimes a smile seems to be so much more appropriate and appreciated than a word.

Johnnie got his shoes on today all by himself for the first time, and just for that moment it didn't seem to matter that they were on the wrong feet.

As I near home I realize that the nursery-school day is over and somehow all the things that happened all during the day really do matter. There were so many happy moments. And then there were confusing, conflicting moments too, that both the children and I had to face. And our needs—the children's and mine—they are the same—dependable affection—endless patience and tolerance . . .

Lalla Mary Goggans

• IN THE NEWS

Governors Report on State Committees for Midcentury Conference

When Oscar R. Ewing, Federal Security Administrator, wrote to State Governors regarding State and local committees to develop plans for the Midcentury White House Conference on Children and Youth—either designation of existing bodies or appointment of new ones—he laid particular stress on citizen participation. His letter said in part:

". . . We hope for the assistance of the Governors in encouraging the broadest kind of State participation through State Midcentury White House Conference committees . . . It is planned that the National Committee will work closely with the official State groups, so that through them there can be brought together the thinking and leadership, the plans, the hopes, and the aspirations of those who are closest to children and young people in their families and their communities. Suggestions and recommendations from State groups will be invited toward assisting the National Committee in its work. The State committees are expected to form the nucleus of study groups, survey activities, and discussion forums, which will help dramatize children's needs, make available the latest scientific information about developments in children's services, and provide media for post-Conference follow-up activities to the Midcentury White House Conference on Children and Youth.

"I shall be grateful, as chairman of the National Committee, if you will advise me of your action with regard to the designation of an existing body, or, if necessary, the creation of a special representative citizen committee, to serve as the State committee for the Midcentury White House Conference on Children and Youth. Would you be good enough to inform me of the membership of the committee, and the name and address of the chairman, in order that the National Committee may promptly establish a channel of communication with your State group?

"I believe that this Midcentury White House Conference can make a signal national contribution to the advancement of the well-being of our children. To do this, however, we need the help and participation of the Governors and of all the people of this Nation."

As of October 31, 1949, responses had been received from 37 States and Territories and the District of Columbia, indicating that committees for the Midcentury White House Conference on Children and Youth are being established.

In 23 of these States and Territories committees have already been designated or appointed, as follows:

Alabama State Advisory Committee on Children and Youth.

Arkansas Council on Children and Youth.

California Youth Committee.

Connecticut State Planning Group for the Midcentury White House conference.

District of Columbia Committee for the Midcentury White House Conference.

Florida Children's Commission.

Georgia Congress of Parents and Teachers.

Iowa Commission for Children and Youth.

Louisiana Committee for the Midcentury White House Conference.

Minnesota Youth Conservation Commission.

Missouri Committee for the Midcentury White House Conference.

New Hampshire Committee for the Midcentury White House Conference.

New Mexico Committee on Children and Youth.

North Carolina Conference for Social Service.

Ohio Commission on Children and Youth.

Oregon Governor's Committee on Children and Youth.

South Carolina Citizens' Committee on Children and Youth.

Texas Youth Development Council.

Virginia Committee for the Midcentury White House Conference.

Virgin Islands Committee for the Midcentury White House Conference.

West Virginia Committee for Children and Youth.

Wisconsin Commission for Children and Youth.

Wyoming Youth Council.

The Governors of the following States and Territories have indicated that they are giving consideration to the appointment of committees for the Midcentury White House Conference: Alaska, Colorado, Delaware, Illinois, Maine, Massachusetts, Nevada, New York, North Dakota, Oklahoma, Puerto Rico, South Dakota, Tennessee, and Utah.

Children's Fund Ships 5,000 Tons of Supplies

Marking the second anniversary of its first shipment of supplies to needy children in war-devastated Europe, the United Nations International Children's Emergency Fund (UNICEF) recently moved, in a week, over 5,000 tons of foodstuffs and goods to nine different European countries.

The shipments included 1,500 tons of dried milk from the United States; with additional supplies of milk, margarine, meat, and soap from New Zealand and Australia; cod-liver oil and 15,000,000 vitamin capsules from Canada, made from New Zealand shark-liver oil; and 19 cases of penicillin from the United States.

UNICEF officials have also announced a drive to combat rickets among German children. It is expected that more than 1,000,000 children will be assisted during the campaign, which will last through the coming winter.

New York City Compiles Standards for Care of Premature Infants

New York City's Bureau of Child Hygiene, of the Department of Health, has prepared a statement of "Recommended Standards for the Care of Premature Infants in New York City." These recommended standards have been compiled from the existing standards set up by various pediatric and obstetric groups throughout the country, says the statement, in the hope that they will be useful in guiding the discussion of different groups interested in better care for prematurely born infants in New York City.

●

"The safeguarding of the rights of our citizens must be accompanied by an equal regard for their opportunities for development and their protection from economic insecurity. In this Nation the ideals of freedom and equality can be given specific meaning in terms of health, education, social security, and housing."

President Harry S. Truman, January 7, 1948.

• FOR YOUR BOOKSHELF

INTERNATIONALE FRAGEN DER GESUNDHEITSFÜRSORGE UND FÜRSORGERISCHEN AUSBILDUNG (International Problems of Health Work and of Training for Social Service), by Prof. Walter A. Friedlander. Reprint from Gesundheit und Wohlfahrt (Health and Welfare), Zurich, Switzerland, 1949. No. 4, pp. 157–163.

The author, associate professor of social welfare at the University of California, brings out effectively the highlights of the International Conference on Social Work held last year in Atlantic City and New York. (This was the fourth conference of its kind; the others were held in Paris, 1928; Frankfurt-on-the-Main, 1932; and London, 1936.)

The delegates from many lands discussed housing, health, and social-work training in the light of postwar developments. They agreed on the urgency of two problems: (1) The need for improving the health conditions among children and (2) the lack of adequate facilities for social-work training. The delegates of the great countries of the East pointed out that the health conditions among their 800 million people were so distressing that other problems seemed insignificant by comparison. In India, for example, owing to lack of medical personnel, a quarter of a million mothers die in childbirth every year. Equally distressing is the situation in China and in Egypt, particularly in the rural areas; but in the latter country a Ministry of Rural Life has been recently created, and, in co-operation with a private agency, it has sent physicians, midwives, and nurses to rural districts. The reports of conditions among rural Indians in Latin America were also discouraging.

Training for social work was enthusiastically discussed by the delegates. They agreed on the necessity for appointing to positions in social work only persons trained in properly equipped schools, though they realized that the world is still very far from this goal. Although good schools are available in many European countries and in the United States, Canada, and Australia, they are lacking in China, India, Japan, and parts of Africa and Latin America. In still other countries, the institutions designated as schools of social service are entirely inadequate. The conference urged that good schools be established as soon as possible by the countries in which they are lacking; and that in the meantime other countries should help by offering regular training and accelerated courses.

Finally, a hope was expressed by the conference that, under the auspices of the United Nations and other international organizations, an attempt would be made to provide training in social work with the aid of training grants, seminars, and international exchange of teachers.

Anna Kalet Smith

PEDIATRICS AND THE EMOTIONAL NEEDS OF THE CHILD; as discussed by pediatricians and psychiatrists at Hershey, Pa., March 6–8, 1947. Edited by Helen L. Witmer. Commonwealth Fund, New York, 1948. 180 pp. $1.50.

This "selective report" summarizes the contributions of about 50 pediatricians, psychiatrists, and psychiatric social workers, who were invited by the Commonwealth Fund to discuss the integration of the mental with the physical aspects of child care.

At the outset of the conference an attempt was made to define the role of the pediatrician in dealing with emotional factors in child and family life. Several sessions were devoted to the training needed to prepare the medical student, and more specifically the pediatrician, for practicing medicine more "comprehensively."

The innumerable opportunities which already exist for teaching emotional growth and development in out-patient departments and in hospital wards were pointed out. The use which departments of pediatrics can make, and are making, of psychiatrists, psychiatrically-trained pediatricians, and psychiatric social workers to broaden the scope of pediatric teaching show an acknowledgment of the contribution of other disciplines to child care.

Further information on current programs to meet the emotional needs of children is given in an appendix made up of reports from 10 different hospital teaching centers.

The book shows the progress which has been made in evaluation of pediatric thinking—from a beginning which emphasized the purely physical to at least a recognition of pediatrics as a science and an art embracing the whole child. It is clear that pediatricians feel competent in the area of physical growth and development, that they are unsure of themselves, but that they are ready to go forward in the area of emotional growth and development.

Alice D. Chenoweth, M. D.

• CALENDAR

Dec. 1–3—American Public Welfare Association. Annual Round Table Conference. Washington, D. C.

Dec. 7—Committee on Conference Program, Midcentury White House Conference on Children and Youth. Washington, D. C.

Dec. 15–16—National Committee of Midcentury White House Conference on Children and Youth. White House.

Dec. 27–30—American Statistical Association. Annual meeting. New York, N. Y.

Dec. 27–30—American Economic Association. Annual meeting. New York, N. Y.

Dec. 28–30—American Speech and Hearing Association. Twenty-fifth annual conference. Chicago, Ill.

Dec. 28–30—American Political Science Association. Annual meeting. New York, N. Y.

Dec. 29–31—National Council on Family Relations. Annual conference. New York, N. Y.

Jan. 19–20, 1950—National Social Welfare Assembly. Annual Meeting. New York, N. Y.

Area conferences, National Child Welfare Division, American Legion:

Dec. 1–3, 1949. Area E—Alaska, Arizona, California, Colorado, Hawaii, Idaho, Montana, Nevada, New Mexico, Oregon, Utah, Washington, and Wyoming. Seattle, Wash.

Jan. 13–14, 1950. Area D—Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Missouri, Nebraska, North Dakota, Ohio, South Dakota, and Wisconsin. Topeka, Kans.

Feb. 3–4, 1950. Area B—Delaware, District of Columbia, Maryland, New Jersey, New York, Pennsylvania, Puerto Rico, Virginia, and West Virginia. Atlantic City, N. J.

Mar. 3–4, 1950. Area C—Alabama, Arkansas, Florida, Georgia, Kentucky, Louisiana, Mississippi, North Carolina, Oklahoma, Panama, South Carolina, Tennessee, and Texas. Dallas, Tex.

Mar. 10–11, 1950. Area A—Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont. Hartford, Conn.

Illustrations:

Covers: Federal Security Agency.

Pages 66, 67, Blakeslee-Lane for George Washington University.

Pages 68–71, from Developmental Diagnosis, by Arnold Gesell, M. D., and Catherine S. Amatruda, M. D.

Page 72, Royal Norwegian Information Services.

Page 74, National Youth Administration.

HELP TO SAVE THE RURAL MOTHER AND BABY

In rural America today too many mothers die in childbirth, and too many babies die soon after they are born. The risk of a baby's dying in his first year of life is nearly one-third greater in isolated counties than in or near any of our great cities. For mothers in these counties the risk of dying from causes associated with childbearing is more than 50 percent greater.

Analysis of deaths during the 5-year period 1943–47 shows that for each 1,000 babies born in or near a great city, 31 died before their first birthday. But for each 1,000 born in isolated counties, as many as 41 died. For mothers, the difference between the death rates in highly urban counties and in rural ones was even greater. For each 10,000 live births, 15 mothers died in greater metropolitan areas, but 23 died in isolated counties.

As a Nation we are making childbirth increasingly safe. Both the infant and the maternal death rates have been going down steadily for some years. Present rates compare favorably with those of other countries.

Also we have recently reduced the gap between the lower infant death rates in the greater metropolitan counties and the higher rates in isolated counties. But for maternal deaths the gap has widened. Both these gaps should be done away with by making medical and hospital services available to mothers and babies in rural regions.

Small rural hospitals should be able to handle most births and should be able to offer the mother adequate antepartum care from early in pregnancy until time for delivery. Such care will eliminate many of the conditions that make childbirth hazardous. But if complications arise the skills and resources of big hospitals must be rushed to the mother, or she must be brought in quickly to such a hospital. Mothers who hemorrhage in childbirth must get the right type of blood quickly. When infections occur, laboratory tests that can be made quickly are essential, as well as proper treatment. A skilled obstetrician is especially needed if a severe toxemia develops.

The Children's Bureau is helping the States to develop a network of health services that will reach more rural mothers and babies. Under the authority given it by Congress, the Bureau allots a larger Federal grant per birth to States in which the proportion of births to families in rural areas is above the average for the Nation. Continuing emphasis needs to be placed on fulfilling the needs of rural mothers and babies.

We know that children in isolated counties are receiving one-third less medical care than are those in or near large cities. In greater metropolitan counties there are nearly 6 doctors to every 1,000 children, but in isolated counties only 1 or 2 doctors per 1,000 children. In metropolitan and adjacent counties there are 15 general-hospital beds per 1,000 children; in isolated counties, 8. In 2,000 of the Nation's 3,000-odd counties—where 31 percent of our children live—no well-child clinics are held.

This dearth of care in rural America is one reason why so many mothers and babies die there. Although State health departments are broadening their maternal and child-health services to reach their outlying regions, they need much more help than they are getting now if good medical and hospital care is to be within reach of all their mothers and babies.

All this points to a job for every citizen of every State. The job is to help to expand the State's maternal and child-health services so that they will reach out to the mothers and children in the most isolated regions of the State.

Leona Baumgartner

LEONA BAUMGARTNER, M. D.
Associate Chief, Children's Bureau

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the CHILD

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Managing Editor Sarah L. Doran
Art Editor Philip Bonn

FEDERAL SECURITY AGENCY
Oscar R. Ewing, Administrator

SOCIAL SECURITY ADMINISTRATION
Arthur J. Altmeyer, Commissioner

CHILDREN'S BUREAU
Katharine F. Lenroot, Chief

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U. S. GOVERNMENT PRINTING OFFICE: 1949

DECEMBER • 1949

the CHILD

The Children's Bureau, concerned with the well-being of all the children of the Nation, reports to the people every year what is happening to children.

This year it is more important than ever to consider the great surge of new life that has come with the increased birth rates of postwar years. How can we make this mean the greatest number ever of healthy, happy, productive grown-ups?

U. S. SUPERINTENDENT OF DOCUMENTS
JAN 6 1950

1/3 of the Nation is YOUNG

how young

Most of our families are small ones, but most of our children live in large families. Sounds contradictory, but it's true. Over half (51 percent) of the Nation's 46 million children under 18 years of age live in 15 percent of our families who have three or more children. One-third of all children are in 7 percent of the families that have four or more children.

The "typical" American boy and girl grow up in a family complete with father and mother. (With divorce rates decreasing from 4.3 per 1,000 population in 1946 to 2.8 in 1948, perhaps their chances to do this will increase.) Six million children, however—one in every eight—live with only one parent, with relatives, in foster homes, or in institutions.

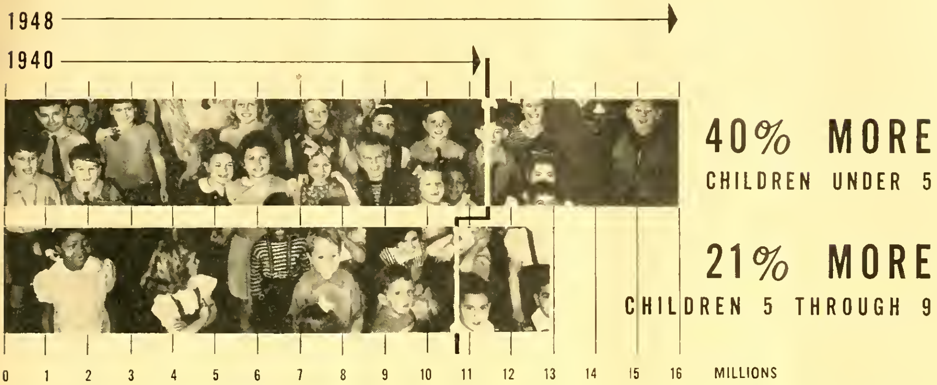
Families with the most children usually have the lowest incomes. The average (median) for all families in 1947 was $3,031. Families with four or more children had $2,731. It cost city families from $3,004 to $3,458 to buy the most *modest* living for a family of four people. By 1948, 3 in every 10 families were spending more than they earned that year.

Area of special need:
Families with many children.

Area of special need:
Children without mothers or fathers.

Area of special need:
Low-income families.

Almost one-third of our Nation is under 18 years (31.4 percent). War years brought so many babies, we now have 40 percent more young ones under 5—and 21 percent more children 5 through 9—than we had in 1940. Because birth rates were going down before the war, there are 7 percent fewer children 10 through 14—and 13 percent less who were 15 through 17—than in 1940. **But the over-all picture is that we now have the largest number of children under 18 the Nation has ever had—46 million.**



America lives

One out of every 10 families is headed by a woman; two-thirds of these women are widowed or divorced. Such families had an average income of $2,172 in 1947. One out of every five mothers—4.2 million—with children under 18 had a job outside her home. Over 1½ million of these mothers had children under 6. This means problems of substitute care.

More than one in every four youngsters 14 through 17 years of age—2.2 million of them—had full- or part-time jobs in the spring of 1949. That was twice the number with jobs in 1940. Included in the 2.2 million were ¾ million boys and girls 14 and 15 years old, three times the number in 1940 who had jobs. Child workers in industrialized agriculture need special protection.

"Where shall we live?" continued to harass millions of families. Too much of postwar new housing has been beyond the reach of low-income families. Too many existing places are below decent standards. Even decent living quarters are too often overcrowded. But the passage of the Housing Act of 1949 opens up hope for the future.

Area of special need:
Families of employed mothers.

Area of special need:
Children who are employed.

Area of special need:
Low-cost homes.

being born is safer for MANY

but not for ALL

The safest year in our history for mothers to have babies was 1948. Yet even in this banner year, 4,070 mothers—11 for every 10,000 live births—died in childbearing.

We know how to save many of these mothers. Some States are far ahead of the average for the Nation. Minnesota, in the lead, lost only 6 mothers per 10,000 live births. From 1940, our last prewar year, to 1948 we cut maternal death rates 71 percent for the Nation as a whole. Even States with poor records made dramatic gains: Alabama, for instance, cut her rate of 61 deaths per 10,000 live births down to 26.2.

We need particularly to extend health protection to nonwhite mothers. Childbearing is still three times as risky for them as for white mothers. Nearly five times the percentage of nonwhite mothers as white mothers in 1948 were delivered without the advantages of hospital facilities.

Babies, as well as mothers, fared better in 1948 than in any earlier year. Their death rate was 31.8 per 1,000 live births. This added up, though, to 113,000 who died before reaching their first birthday.

Many of these were needless deaths, as we know from the experience of Oregon, where the infant death rate in 1947 was 24.7. We have come a long distance in the few years from 1940, when the infant death rate was 47.0, but we have much farther to go. (If 1940's rate had held in 1947, we would have lost 55,000 more babies than actually died in the latter year.) We have much of the know-how; what we need is the do-it.

Nonwhite babies, like nonwhite mothers, suffer the greatest risks. Their death rate is more than half again as high as the rate for white babies.

Among all the causes of baby deaths, the most important is premature birth. (In fact, prematurity is the eighth leading cause of all deaths in the Nation.) Of the 119,000 infants who died in 1947, 41,000 were prematurely born.

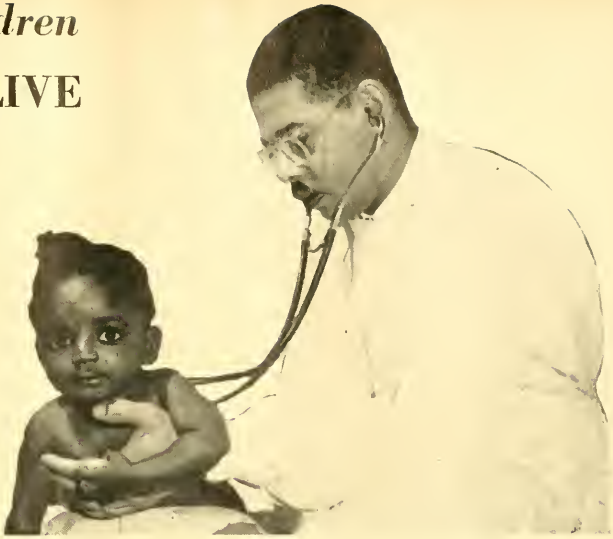
Special projects, helped by Federal grants and encouraged by bureau specialists, are doing a pioneering job for these smallest of our new citizens: training nurses and doctors in their care; supplying incubators; developing special centers in big hospitals to which prematures can be rushed from homes and other hospitals unequipped to give these undersized and underdeveloped babies the highly skilled care they must have to live.

Within the last few years, with the help of Federal funds, centers for "preemies" have been set up in Colorado, Hawaii, Illinois, Louisiana, Maryland, New York, North Carolina, Tennessee, and West Virginia. In 1949, several other states were making plans for such centers.

EMIC PROGRAM

Midnight of June 30, 1949, marked the end of the greatest public maternity care program ever undertaken in the United States. At that moment, the wartime Emergency Maternity and Infant Care program passed into history. During its 75 months—from April 1943 through June 1949—EMIC authorized payment for the maternity care of 1,223,000 mothers and for the medical care of 231,000 babies who became sick in their first year. The Nation footed the bill—$127,000,000 ($92 was the average for maternity cases; $64, for sick babies). Nearly half our doctors and 90 percent of our hospitals cooperated in this public program to provide maternity care for wives of enlisted men in the four lowest pay grades of the armed forces, and of aviation cadets, and medical, nursing, and hospital care for their infants up to 1 year of age.

we are keeping more children ALIVE



—but not keeping them all WELL

As our baby death rate has dropped, death rates among older children have dropped, too. For children 1 through 4 years of age the rate in 1947 was 45 percent lower than in 1940. For youngsters 5 through 14, 1947's rate of death was a 30 percent improvement over 1940's.

We've made great progress in treating the infectious diseases of children with antibiotics. As infectious diseases decrease in importance, cancer and leukemias move up. But accidents still kill more children over 1 year of age than any single disease.

We're understanding better the emotional, as well as physical, needs of the sick child. Some hospitals are relaxing their rigid attitudes . . . encouraging parents to be with their sick children . . . letting mothers help with their nursing . . . starting play groups for convalescent youngsters. As State planning for new hospitals under the Hill-Burton Act goes on, prospects for better services to mothers and children—better delivery rooms, nurseries, clinics, more help to outlying districts—improve.

It is not enough to reduce children's deaths. Well children must be kept well. Sick children must be made well, and children with handicaps helped to overcome or adjust to them. For this, parents must be within pocketbook and travel distance of medical care and health services.

NOW WE HAVE *FACTS*

Thanks to the first study of medical care and health services for children ever made in this country, a joint project of the American Academy of Pediatrics, the United States Public Health Service, and the Children's Bureau, we now know that on any day in the year 14 out of 1,000 children are likely to be getting some kind of medical care. Eleven of the fourteen will be cared for by private physicians. Some children could use much more medical care if they had the chance. Children in New York, for instance, get twice as much care as those in Alabama. Doctors are more plentiful in rich States and in cities. We know now that community health services and clinics are still rare. Only 16 percent of the general hospitals in the country have out-patient clinics, and these are in large cities. Two thousand counties (of our 3,000-plus) have no well-child clinics, yet nearly a third of all children under 5 live in these counties. Over half our counties have no elementary school that offers a health examination by a doctor.

AREAS OF SPECIAL NEED

Nonwhite children.

Children outside big cities.

Children with special handicaps.

toward a **HEALTHIER** *Nation*

To help make health care accessible to children, Congress, under the Social Security Act, appropriates each year $11 million for grants to States which they can use to extend and improve their maternal and child-health services, and $7.5 million to extend and improve services for crippled children. The Children's Bureau administers these grants, approves State plans for using this Federal money, and advises with State agencies on the development of their programs.

States share in the Federal money in varying amounts, depending partly on the number of children they have and partly on their need for help in providing services. To take full advantage of the Federal grants, the States must match half. Part of the remaining half is used for special projects of Nationwide importance.

Most of the services provided by State and local health departments for mothers and children help well mothers and children keep well. Such services include prenatal clinics, public-health nursing, well-child clinics, immunization, health examinations of children of school age. In limited ways, States provide treatment for a few mothers and children who become ill.

State crippled children's services, supported in part by the $7.5 million, include free diagnosis, and payment for, or help in finding, skilled care in hospitals, in convalescent and foster homes, and in children's own homes. There are so many children with handicaps, and the money is so limited, most of it goes for the care of children with orthopedic handicaps. At the beginning of 1949, State agencies had on their lists the names of 30,000 crippled children who couldn't get care because there wasn't money enough. Toward the end of the fiscal year 1948–49, Congress appropriated an extra $750,000 for these children. But that could help only a part of them.

The well-staffed maternal and child health division in today's public health department, in States and communities, has not only doctors and nurses, but consultation also from social workers, nutritionists, psychologists, dentists, and other child specialists. These workers pool their knowledge and work together in developing and extending health services for children. The same is true in services for crippled children.

This team idea is an idea basic to public-health services for children that has grown with the Social Security Act. It is the idea, too, behind the Children's Bureau, whose doctors, nurses, medical social workers, nutritionists, mental-health specialists, child-welfare workers, and other specialists pool their know-how and work together in behalf of children.

The programs where this new viewpoint shows up best are those which States are conducting for the care of a limited number of crippled children. These special projects for handicapped children often lead to greatly increased State financing. In California, where a rheumatic-fever project was financed entirely from Federal funds for 8 years, the legislature, in 1949, appropriated $500,000 for the work.

State and local maternal and child health services, aided by Federal grants, 1948

Medical services

Mothers admitted to antepartum medical service	153, 000
Mothers given postpartum medical examination	45, 000
Infants admitted to medical service	264, 000
Preschool children admitted to medical service	379, 000
Examinations by physicians of school-age children	2, 072, 000

Public-health nursing services

Mothers admitted to antepartum nursing service	229, 000
Mothers given nursing service at delivery	7, 000
Mothers admitted to postpartum nursing service	223, 000
Infants admitted to nursing service	530, 000
Preschool children admitted to nursing service	542, 000
Field and office nursing visits for school-age children	2, 427, 000

Immunizations

Smallpox	1, 403, 000
Diphtheria	1, 545, 000

Dental inspections

Preschool children	53, 000
School children	2, 038, 000

Children receiving service from State crippled children's agencies, aided by Federal grants, 1948

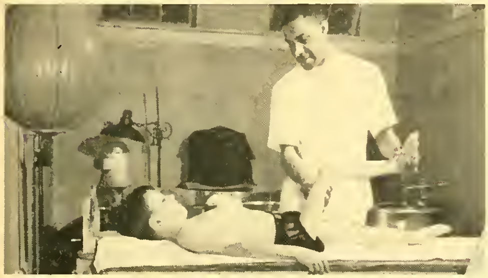
Hospital in-patient care	30, 000
Convalescent-home care	5, 000
Clinic service	131, 000
Physician's service outside clinics, hospitals, convalescent homes	11, 000

Children with cerebral palsy

One city in New York finds that three times as many people are handicapped by cerebral palsy as by polio. Yet cerebral-palsied children receive only a fraction of the attention and money spent on children with polio. Special projects for cerebral-palsied children were in operation in 1949 in Alabama, Kentucky, Maryland, Minnesota, Mississippi, Montana, New Jersey, and Hawaii. New York's State legislature, following up on California's special appropriation in 1947 of $1,000,000 for cerebral-palsied patients, voted $500,000 in 1949 for theirs.

Children with rheumatic fever

By 1949, 25 States or Territories, aided by Federal funds, had established special programs for the care of these children. They were Alaska, Arizona, Arkansas, California, Connecticut, District of Columbia, Hawaii, Iowa, Maine, Maryland, Massachusetts, Michigan, Minnesota, Missouri, Nebraska, New Jersey, New York, Oklahoma, Rhode Island, South Carolina, Utah, Virginia, Washington, West Virginia, Wisconsin. Big clinical news of the year was the demonstrations of new treatments—with cortisone and ACTH.



Children with polio

With the second worst polio epidemic in its history threatening the country, public and private agencies closed ranks for their rescue work. On invitation of the Children's Bureau, representatives of State crippled children's agencies met in May 1949 with representatives of the National Foundation for Infantile Paralysis to develop closer teamwork in diagnosing, treating, and rehabilitating children attacked by this still mysterious disease.

Children who are hard of hearing

More clinics for these children were held in 1949 than in any earlier year. The experts are discovering more can be done for the very young children with poor hearing than was believed possible. Many States are using diagnostic techniques developed by the military during the war. Federal funds in 1949 helped to finance special hearing projects in Maine, Maryland, Oklahoma, South Dakota, and Wisconsin. They were used also to buy hearing aids for some children in some States.

Children with tooth troubles

Fifty thousand children in 35 States were treated with sodium fluoride in 1949, thanks to the special program of the United States Public Health Service, financed by Congress with a special grant of $1 million. Many communities are now organizing continuing programs of their own, as part of their regular maternal and child-health work. Eighteen communities are adding fluorides to their public water supplies.

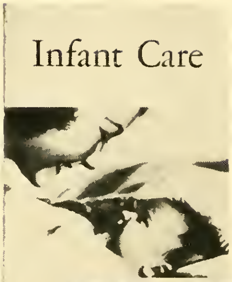
for parents

← CHILDREN'S B

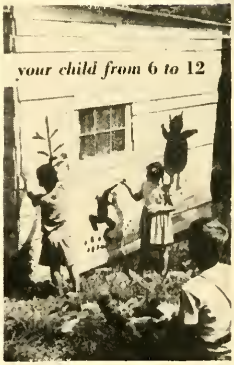
These illustrated bulletins tell how normal children grow physically, emotionally, and socially, from conception through adolescence. *Prenatal Care*, first published in 1913 and revised at intervals since, was completely rewritten in 1949. *Your Child from Six to Twelve* made its first appearance in 1949. In its first 6 months, a quarter-million copies were sold by the Superintendent of Documents. All kinds of adults, not parents only—teachers, nurses, doctors, social workers, club leaders, and others—can get some new slants and fresh ideas in their work and play with children from these bulletins. All five, based on the experience and opinions of a wide variety of child specialists, give sane, middle-of-the-road suggestions about child care. They ride no hobbies.

Individual copies may be purchased from the Superintendent of Documents, Government Printing Office, Washington 25, D. C. The Children's Bureau has only limited supplies of free copies.

prenatal
care



YOUR CHILD
FROM ONE TO SIX

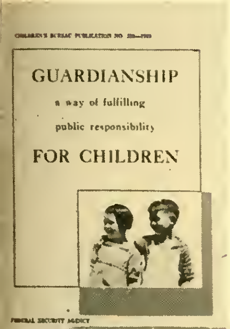


Guiding the
ADOLESCENT

PUBLICATIONS ➔

for professional workers

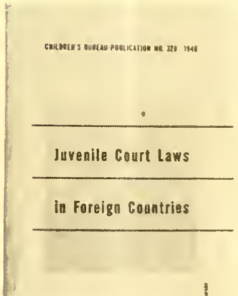
The Children's Bureau mandate from Congress, in the 1912 act which created the Bureau, to investigate and report "upon all matters pertaining to the welfare of children and child life among all classes of our people" is a broad order. With the limited staff for such investigations and reports, not many areas can be covered. But each year the Bureau publishes new data and guides for the use of professional workers that are based on its recent observations and study. Those shown on this page were published in 1949. Free copies of all (except "Premature Infants" which is available only from the Superintendent of Documents, Government Printing Office, Washington 25, D. C., for $1.25 a copy) can be had from the Bureau by interested professional and administrative workers.



CHILDREN'S BUREAU PUBLICATION NO. [illegible]

GUARDIANSHIP
a way of fulfilling
public responsibility
FOR CHILDREN

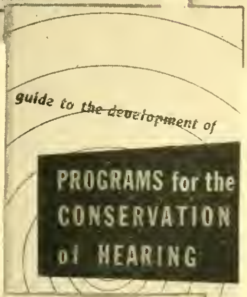
FEDERAL SECURITY AGENCY
Social Security Administ
Children's Bureau



CHILDREN'S BUREAU PUBLICATION NO. 328 1949

Juvenile Court Laws
in Foreign Countries

SECURITY AGENCY · Social Security Administration
Children's Bureau



guide to the development of
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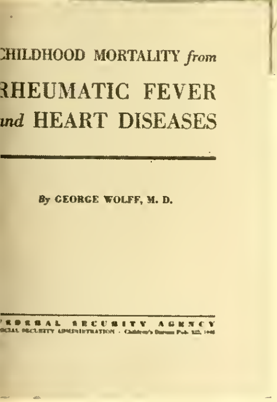
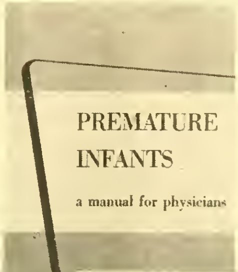
CONSERVATION
of HEARING



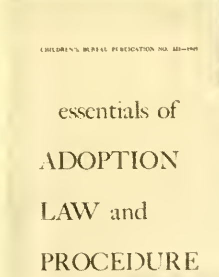
CHILDHOOD MORTALITY *from*
RHEUMATIC FEVER
and HEART DISEASES

By GEORGE WOLFF, M. D.

EDERAL SECURITY AGENCY
CIAL SECURITY ADMINISTRATION · Children's Bureau Pub. 322, 1948



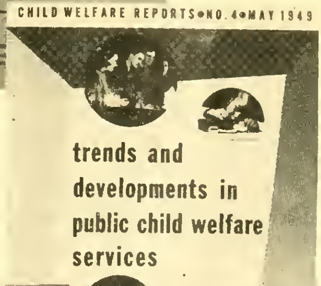
PREMATURE
INFANTS
a manual for physicians



CHILDREN'S BUREAU PUBLICATION NO. [illegible]—1949

essentials of
ADOPTION
LAW and
PROCEDURE

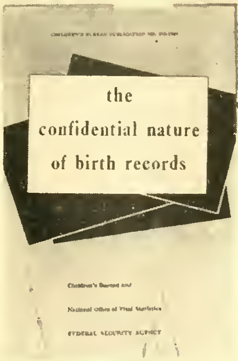
FEDERAL SECURITY AGENCY
Children



CHILD WELFARE REPORTS • NO. 4 • MAY 1949

trends and
developments in
public child welfare
services

CURITY AGENCY • SOCIAL SECURITY



CHILDREN'S BUREAU PUBLICATION NO. [illegible]

the
confidential nature
of birth records

Children's Bureau and
National Office of Vital Statistics
FEDERAL SECURITY AGENCY

a State [illegible]
STAFF DEV[illegible]
CHILD [illegible]

FEDERAL SECURITY AGENCY
[illegible]
CHILDREN'S BUREAU [illegible]

when a child needs a FRIEND

A child has the best chance for a good start in life in a family that has security, good health, and understanding of children's needs. When his home breaks down in any way, somebody has to come to the rescue. That "somebody" may be a relative, a neighbor, a private organization, or the community. Reenforcing them is the State, with its body of laws that express, in one way or another, the responsibility of all citizens to be a friend to the child deprived of a decent chance in life, who has been neglected or abused, who has lost his parents, or whose father and mother need help with their job as parents. Helping States to develop and extend their services for such children is the Federal Government which, ever since the passage of the Social Security Act in 1935, has had this responsibility.

Our various forms of social insurance and public assistance do much to underpin a family's economic security, and so increase the chance its children have for a normal childhood. But the kind of security children need comes principally out of the affection and protection of parents, out of their understanding of how children grow, and out of their imagination and ingenuity in making life worth-while.

Public and private child-welfare services are designed to help parents, who need such assistance, to give their children this good start in life and to find the best possible solution when something goes wrong at home. The child-welfare worker, especially trained to deal with the problems of children, works with families and through many kinds of community services, agencies, and institutions to bring help to such children.

Over the years, child-welfare services have increased in variety and skills as people have grown toward a deeper awareness of what individuals need in childhood for sound physical, emotional, and social growth. More and more, as child-welfare workers help in meeting the problems of children in trouble, they are seeing that an important part of their job is to promote good community planning for children. Neighborhoods with good provisions for children usually have fewer children in trouble.

Child-welfare services are provided under both public and private auspices. Both are essential.

With a few exceptions, every State has a public welfare department with a child-welfare division or other administrative unit with responsibility for the child-welfare program.

State legislation usually spells out the responsibilities of welfare departments toward children: to administer or supervise child-welfare activities; to assure the protection of children in certain situations; and to promote the well-being of children and youth.

The organization through which *public* services reach children is often the child-welfare unit in a county welfare department.

Although the legal basis exists in many States, no State as yet has as well-rounded, well-developed, and comprehensive a program of child-welfare services, given under both public and private auspices, as is needed.

Federal grants to the States for extending and improving child-welfare services account for $3.5 million of the annual $22 million authorized by the Social Security Act for the promotion and extension of health and welfare programs. Each State receives $20,000 and shares in the balance according to the proportion of its rural population to the total United States rural population. To take advantage of this help from the Federal Government, each State must assume some of the cost of services in rural areas, although no fixed amount of Federal funds must be matched.

States spend from their own and local funds considerably more than the amount of the Federal contribution to their welfare programs, but how much is not known. Nor is there a complete report on what State legislatures in 1949 did to increase or decrease appropriations for these services. Many States reported that rising costs of administration and of maintenance of children were pressing hard against their budgets and in some instances forced them to reduce their services. Few could look forward to expanding their programs.

When a child needs a temporary mother

A specially trained homemaker, working under direction of a child-welfare agency, can do a lot to hold families together when the mother must go to the hospital or is ill at home. Some State welfare departments are beginning to use Federal funds for this type of service, especially in rural counties. The National Committee on Homemaker Service, with which the Bureau works, gives expert counsel on new programs. Many Councils of Social Agencies are looking to this service to reduce the need for temporary foster care of children whose mothers need substitutes.

When a child needs a temporary home

Searching for, selecting, and supervising foster homes for care of children who cannot, or should not, stay with their own families, is one of the big jobs of child-welfare workers. In these days of housing shortages and the high cost of living, it isn't easy to find homes. State after State reports to the Bureau its need for more funds for foster-family care. In 1948, for the first time, plans were worked out for using Federal child-welfare service funds, to a limited extent, to pay the cost of temporary care of certain children in foster homes. Twelve States budgeted Federal funds for this purpose in 1949. Few increases in State funds for foster-family care were reported in 1949. Only four States and a few scattered cities had public funds for day care for children of working mothers.

When a child needs a permanent home

Slowly but surely, the movement to encourage or require families who want to adopt children, and parents who have children for adoption, to use child-placing agencies is growing, helped along by public alarm over the "black market" in babies. It is estimated that at least 50,000 children are legally adopted each year. Many of the 44 State and Territorial legislatures, meeting in 1949, either passed new, or amended existing adoption legislation. A number of these measures were influenced by the Bureau's *Essentials of Adoption Law and Procedure*. The practice of placing children for adoption without the aid of skilled service from a child-welfare agency, however, continues widespread.

When a child needs to live with other children

There will always be times when some children can gain more from living with other children than from living with a family. For them, the right kind of institutional care is very important. Increasingly, directors of institutions are looking to child-welfare workers for help in providing for all children under care the services that will best meet their special needs. Some States are showing more appreciation of the value of case-work services within the institution, with the child's own family while the child is being placed, and while he is living in the institution, and in developing follow-up plans when the child returns to his home.

When a child is delinquent

Juvenile delinquency *appears* to be on the downgrade, but some 275,000 boys and girls were brought before juvenile courts last year as delinquents. Most children referred to juvenile courts continue to live in their own homes while their cases await decision. However, some children are kept in police stations and common jails. Some 20,000 children each year are committed to public institutions. From almost every region in the country reports are received of the desire of State training-school administrators to improve their care of delinquent youth. Some of the recent State legislation on services for delinquent children and youth shows growing interest in comprehensive and centralized programs for dealing with juvenile delinquency.

When a child is born to an unmarried mother

With more than 100,000 babies born out of wedlock each year, problems of unmarried mothers and their babies add up to a sizeable concern to many public and private child-welfare agencies. These agencies are doing an increasingly skillful job of meeting the individual needs of each mother and baby; making sure that each gets good medical and nursing care; and providing case workers to help mothers plan their own and their babies' future deliberately and without fear. Improved methods of birth registration—and simplified birth card—which States are adopting are expected to protect the child who is born out of wedlock.

toward the future - - -

help for ALL *children who need it*

Public services for children have developed hand in hand with voluntary services for many decades in this country.

The Children's Bureau has always recognized that both public and voluntary agencies make important contributions to child welfare, and has always been interested, therefore, in seeing that all facilities, both public and voluntary, are developed and used to the fullest extent to help meet the needs of children.

Private agencies are concentrated largely in urban areas and, for the most part, serve children of a particular faith, age, or race, or with some special type of problem. They give invaluable leadership in improving conditions for children, and are carrying a heavy load. They are the first to admit that they cannot do the whole job of reaching out to all children in the Nation who are in need of child-welfare services.

No figures are available for the country as a whole on the relative number of children served by private and public agencies. Reports from the Community Chests and Councils, Inc., the data covering 40 urban areas, show that in 1947 nearly 75,000 children were receiving some kind of protective or foster care. Nearly three-fifths of the children were under the supervision of private agencies. Of the children in boarding homes, however, 58 percent were under the supervision of public agencies. The Children's Bureau hopes to have a complete count of child-welfare services of both private and public agencies for the first time in 1950.

Some 223,000 children were receiving service from State and local *public* departments of welfare at the close of 1948. This means about 5 out of every 1,000 were getting some kind of help from these agencies. In individual States, the proportions varied from 1 to 15 per 1,000.

Even though figures on all children receiving child-welfare services are lacking, every day's crop of stories in the Nation's newspapers about children in trouble are proof enough that we are a long way from meeting the urgent needs of many children, whether through private or public service.

After 14 years of Federal aid for public child-welfare services, four out of every five counties in the Nation still do not have the full-time services of a child-welfare worker paid from public funds.

When a child-welfare worker is not available, under either public or private auspices, communities often have to make second- or third-rate plans for their children in trouble. The Children's Bureau has many reports of children who have been ordered by the courts to be removed from their own homes because they were neglected or abused but who have had to continue to live under these dangerous conditions simply because there was no one to find them another place to live.

Some parents who are aware that their children are developing serious behavior problems have no place to turn for help.

In many communities, courts have no organized probation services, and no persons skilled in making suitable plans for children.

Superintendents of training schools for delinquent children frequently report that very young children and children whose problems are not sufficiently serious to warrant commitment to an institution for delinquents are sent to them. Many of these children need not have been removed from their homes at all if the parents and the community had been able to turn to a trained child-welfare worker for help.

In a number of communities, children needing foster-family care are being placed on waiting lists because there is not enough money to take care of them.

Over 50,000 children, it is estimated, are detained in jail every year.

Some 25,000 children who have run away from home are dealt with by juvenile courts each year, and States have too few resources for doing something for these youngsters.

More and better child-welfare services are urgently needed to meet many of these problems and others like them. There must be the closest collaboration between public and voluntary agencies in moving toward their common goal of making available to every child the care he needs.

AREAS

OF

SPECIAL

NEED

Care of children needing new homes.

Care of children awaiting court action.

Care of children who have run away.

Care of children of working mothers.

how can we get more people with KNOW-HOW?

The extreme shortage of all kinds of workers with and for children is the greatest roadblock on the route to better care for children with physical, emotional, and social difficulties.

Too few boys and girls have been choosing health and welfare work for their careers. Of those who do enter these professions, too few have specialized training in services for children.

The Academy of Pediatrics study shows that for every 1,000 children, there are nearly six doctors in greater metropolitan areas, but only one, or at best two, in isolated areas. The great bulk of well-child supervision, as well as care of sick children, is in the hands of the general practitioner, but one out of six of them has had no hospital training in pediatrics. The training of both pediatricians and general practitioners is primarily in treating disease, only slightly in the physical and emotional care of the well child.

Forty-five percent of the child-welfare case workers in 1948 were working in 66 counties with cities of 100,000 population or more. For the whole country, there were only 3,629 full-time public child-welfare workers, and another 3,621 workers who were primarily responsible for other welfare programs but who devoted part of their time to child welfare. Salary rates, in these days of high living costs, are not attracting many beginning workers, who are required to have at least a college degree. The average annual salary of a full-time case-worker in 1948 was only $2,509.

To help in overcoming the shortage of children's workers, a portion of the Federal grants for services for children is used each year to finance training.

Health

Twenty-one educational centers in 1949 received grants from States cooperating with the Children's Bureau for the training of health workers. General courses in maternal and child health in the schools of public health at the University of California, Johns Hopkins, and Harvard received financial help from this source. Advanced training in obstetrics and pediatrics was offered physicians by the Universities of Arkansas and Nebraska and by Meharry Medical College. Another training project was approved at the University of Illinois for plastic surgeons, orthodontists, speech therapists, social workers, and others, in the care of children with harelip and cleft palate.

Three training projects for doctors and nurses in the care of premature infants—in New York, Colorado, and Louisiana—received funds. Eight university or college nursing schools received grants to help in financing special courses in maternity nursing and child care for graduate nurses. In 3 centers—Chicago, New Orleans, and Boston—special training is offered medical social workers. Western Reserve gave special field training to nutritionists in public-health work, and Meharry and the University of Tennessee offered postgraduate training in dentistry for children.

Not only for students but also for workers on the job, an understanding of child growth and development is becoming increasingly important. Conferences for teachers, held during the year by the Office of Education, the National Institute of Mental Health, and the Children's Bureau, stressed the implications of this knowledge to teachers. Institutes for physicians, held in the past year by the Commonwealth Fund and the Macy Foundation, have helped to spread among doctors a better understanding of current theories. An interstate conference of representatives from State and local child health and welfare agencies in 8 Western States, held by the Bureau in 1949, gave major attention to the many-sided emotional, mental, and social factors in child growth in the care of convalescent children.

Welfare

An increasing number of States are working out careful plans for staff development on the job for child-welfare workers. These plans provide for the new worker a period of orientation to social work and agency service; educational leave for study in a school of social work; and a period of 6 months to a year of supervised experience after return to the agency before taking on a full workload. During 1949, 13 States budgeted Federal funds to cover the salaries of 97 workers receiving orientation, and 3 States budgeted funds for 42 workers receiving special supervision after educational leave.

More States are also using Federal grants to provide supervised field-work experience for students in schools of social work. Twelve States in 1949 budgeted 19 positions for supervisors of such training units, as against 9 States with 14 such positions the year before.

But the shortages continue serious. **Two questions face every citizen:** (1) How can we get the specialized workers for children that we need? (2) What is the shortage of such workers costing us, through taxes, in the public care of adults who are physically or emotionally sick or nonproductive because in their childhood no skilled person came to their rescue when they were in trouble?

State—National—International
PLANNING *for children*

State

Developments in State and local planning for children and youth represent in various areas the brightest spot in 1949's picture of child welfare.

By midyear, State committees or commissions were active in 36 States and one Territory. Functions of these committees, like their organization, authority, and methods of financing, vary widely. Almost universally, they represent a teaming together of public and private organizations for the improvement of health, welfare, education, recreation, and other services for children and youth. Many have on their agenda preparatory work for a Midcentury White House Conference.

National

The National Commission on Children and Youth, including among its 145 members representatives of 70 national organizations and professional associations, gave its major attention, at its annual meeting in February 1949, to planning for the proposed Midcentury White House Conference.

Purposes of the Commission include assisting national organizations, State planning committees, and State and local officials working for children and youth; encouraging youth participation in planning and developing community services; stimulating concern for children around the world. and action in their behalf through the United Nations and other appropriate organizations; and focusing public attention on the need for strengthening family life and extending opportunities and public and private services to all children, regardless of race or creed.

The Commission's 1949 report. *Moving Ahead For Children and Youth*, points out specific advances that can be made through governmental and voluntary action.

An Interdepartmental Committee on Children and Youth was created in 1948 by the Federal Security Administrator, at the request of the President, to bring together representatives of all Federal departments and agencies with programs for children. This committee took as its major project for 1949 an inquiry into Federal agency objectives in programs for children and youth. Results will be used as a basis for promoting better coordination of services.

Members of the Interdepartmental Committee are from the staffs of the Departments of Agriculture, Interior, Justice, and Labor; the National Military Establishment; the Administrative Office of the United States Courts; the Federal Security Agency; the Housing and Home Finance Agency; the Selective Service. The Bureau of the Budget is represented by a consultant.

A Joint Interim Committee, representing both the National Commission and the Interdepartmental Committee, developed recommendations during 1948 and early 1949 on the Midcentury White House Conference on Children and Youth. These recommendations, which incorporated suggestions from many national health, education, recreation, and social welfare organizations, labor, farm, civic, and church groups, and outstanding individuals who were consulted during the year, were transmitted to the Federal Security Administrator and to the President of the United States. On August 31, the President appointed the official National Committee for the Midcentury White House Conference.

International

International problems relating to children increasingly challenge the generosity and ingenuity of citizens in this country as knowledge of these problems and instruments for dealing with them are sharpened.

Unattached children coming to this country under the Displaced Persons Act of 1948 were an important concern of the Bureau during the year. The Bureau was responsible for designating the agencies to whom admitted children may be referred. A total of 164 agencies in 38 States were approved. From October 1948 to March 1949, the United States Committee for the Care of European Children, the official agency for bringing into the country children qualified under the Displaced Persons Act, had brought over 225 children. As protection for them, the Bureau prepared and distributed to approved agencies a statement of standards for their care in foster homes, in temporary reception centers, and in other group living arrangements.

Since 1941, the Children's Bureau has been one of some 50 Federal agencies participating in a broad program of international cooperation sponsored by the Department of State and coordinated through the Interdepartmental Committee on Scientific and Cultural Cooperation. During 1948–49, Bureau consultants, working in Latin America, gave help to agencies and schools of social work in Brazil, Colombia, and Chile. Some assistance was given to Haiti's Department of Education and Health on services for children. Consultation on public-health nursing was given to Ecuador and to the Mexican-United States Border Public Health Association.

The Bureau planned study programs in this country for specialists in children's services from Peru. Ecuador, Guatemala, and Mexico, and for United Nations fellows from China, India, the Philippines, New Zealand, the Netherlands. and Denmark. In addition, 205 foreign visitors from 43 countries, many of them officially sponsored, visited the Bureau for special observation and program planning.

The Chief of the Bureau continued throughout the year to serve as a member of the Executive Board and Programme Committee of the United Nations International Children's Emergency Fund. From its creation, December 1946 to April 1949, UNICEF had made 400 transoceanic shipments, carrying more than 250,000 pounds of foodstuffs; $4,000,000 worth of clothing materials; and nearly $600,000 in medical supplies. On the latter date, 24 countries were participating in UNICEF's BCG campaign against tuberculosis.

In various other ways the Bureau assisted in the work of the World Health Organization and the United Nations Division of Social Activities.

gathering the FACTS *about child life*

A CLEARING HOUSE of information on research in child life was created by the Children's Bureau in 1948 to do two jobs:

1. To provide investigators with a central source of information about research projects that have been initiated but are not yet concluded. (Such information does not in any way duplicate reports of completed research which appear regularly in professional journals.)
2. To provide the Children's Bureau with a broad view of what's going on in the research field as a basis for planning its own studies and for making suggestions on additional research that is needed, whether it is undertaken under public or private auspices.

During its first year, the clearing house assembled reports of 1,500 studies relating to the emotional, mental, social, and physical growth of children. These reports were contributed by workers in universities, schools, health and welfare agencies, professional organizations, and various research centers throughout the Nation.

These 1,500 projects give a picture of the general directions research is taking in the broad field of child development. Techniques of personality measurement appear to interest more researchers than any other problem of child growth. For the most part, studies in this area are concerned with diagnosing the maladjusted child. In one project, the Rorschach test is being used to compare the responses of 50 normal children with those of neurotic children under therapy. In another, a thematic apperception test is used for diagnosing treatment needs of children who have been referred to a clinic. The question asked in a third project is: What are the differences in children who become delinquents and those who do not, both of whom live in a so-called delinquency area?

Many investigations are under way into the physical, intellectual, and emotional problems involved in learning, by normal, physically handicapped, and mentally deficient children. One study is examining and evaluating as many factors as possible which may account for the discrepancy between the individual's capacity to achieve and his actual achievement. Classroom teachers in various parts of the United States are cooperating in a study of methods teachers might use to study their pupils.

Investigations of racial and cultural factors are frequently concerned with community and family customs and practices and their effect on children. In one center, the child-rearing practices of rural mothers are being examined. In another, researchers are appraising the relations between economic, educational, and sociological factors in the community and indices of intelligence and achievement of school children.

Evaluation of services to children, mainly in the fields of health and welfare, is a fourth category in which many research projects are progressing. Studies of foster care are numerous. One group is trying to find out how effective infant intelligence tests are as an aid in determining child placement. Another is appraising present criteria used in accepting homes for adoptive placement.

Abnormal births, such as stillbirths, premature births, and congenital malformations are being studied, especially in relation to the diet and health of the mother before delivery. In its study of rheumatic fever, one institution is exploring the problem by way of immunology, biophysical and enzyme chemistry, physiology, and nutrition. The effectiveness of immunization against tuberculosis is being looked into.

Long-time studies observe the emotional and physical development of children from infancy to adulthood. In one city, 130 expectant parents, enrolled in a study, are being followed for as much of their life cycle as possible. The physical, psychological, and social growth of their children will be observed from birth through adolescence.

• CALENDAR

Dec. 28–29—Society for Research in Child Development. Biennial meeting. In conjunction with the American Association for the Advancement of Science. New York, N. Y.

Jan. 13–14—American Group Therapy Association. Annual conference. New York, N. Y.

Jan. 19–20, 1950—National Social Welfare Assembly. Annual Meeting. New York, N. Y.

Jan. 22–25—American Association of Schools of Social Work. Thirty-first annual meeting. Milwaukee, Wis.

Area conferences, National Child Welfare Division, American Legion:

Jan. 13–14, 1950. Area D—Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Missouri, Nebraska, North Dakota, Ohio, South Dakota, and Wisconsin. Topeka, Kans.

Feb. 3–4, 1950. Area B—Delaware, District of Columbia, Maryland, New Jersey, New York, Pennsylvania, Puerto Rico, Virginia, and West Virginia. Atlantic City, N. J.

Mar. 3–4, 1950. Area C—Alabama, Arkansas, Florida, Georgia, Kentucky, Louisiana, Mississippi, North Carolina, Oklahoma, Panama, South Carolina, Tennessee, and Texas. Dallas, Tex.

Mar. 10-11, 1950. Area A—Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont. Hartford, Conn.

Illustrations:

Cover, Esther Bubley.

P. 82: (a) Arthur Rothstein, (b) John Collier, (c) Dorothea Lange.

P. 83: (a) New York City Public Schools, (b) Arthur Rothstein, (c) Flanner House.

P. 84: (a) Federal Works Agency, (b) Virginia State Department of Health.

P. 85: All Esther Bubley.

P. 86: Library of Congress.

P. 87: Top downward, (a) Esther Bubley, (b) Philip Bonn, (c) Esther Bubley, (d) Look Magazine, (e) Public Health Service, Federal Security Agency.

Pp. 88–89: Philip Bonn.

P. 90: Esther Bubley.

P. 91: Philip Bonn.

P. 92: (a) Marjory Collins, (b) Jack Delano, (c) Works Progress Administration, (d) Esther Bubley.

P. 93: Upper, George Washington University; lower, William and Mary College.

LET'S ACT NOW

As a people we have set our sights high for our children, and in many ways we are not failing them, as this report of the Children's Bureau shows.

Fewer mothers and babies are dying.

More health services are reaching mothers and children.

We continue to make advances against many childhood diseases, and more help is getting to children with crippling conditions.

We are extending, slowly, the care needed by orphaned, neglected, and delinquent children.

But we are still a long way from our goal of helping all children, who need help, to become secure, happy individuals.

What makes this fact particularly challenging at this time is the enormous increase in our child population, especially of very young children. If we are to move closer to our goal of a good start and a fair chance for all children, and not simply stand still, we have an even greater job to do than ever before. For services need not only to be multiplied; in many areas they need to be modernized, too, in the light of the new understanding of the way emotional and physical factors interact in human growth and of [illegible] environment on his [illegible]

This is a challenge to [illegible] working as parents and [illegible] contributors to and supporters [illegible] many valuable private organiza[illegible] concerned with children, and as stockholders in our community, State, and National governments.

No one approach has a monopoly of the "know how." We need constantly to explore ways of developing closer team play between individual citizens, private agencies, and public services. Many fine examples of cooperative action already exist.

From its national vantage point, the Federal Government can do much to help the States step up both the quantity and quality of their services. It can help to even up the inequalities between the States in their capacity to meet the needs of their children, many of whom when they are grown will move on to live and work in, and possibly become charges on, other regions and States. The States welcome help from the Federal Government in developing new types of service and in increasing an understanding of the standards neces[illegible]ry for effective service. They ask for [illegible]ts on new techniques of giving [illegible] parents and children. They [illegible] opened to more schools [illegible] centers. Many broad [illegible]hild growth and develop-[illegible]n might otherwise never be [illegible]en, can get a hand from the Fe[illegible] Government.

If we are not to continue to deny to some children the chance they need for a safe, healthy, and wholesome childhood, simply because they happen to be born in one State rather than another, or to one family rather than another; if we are not to be satisfied with second-quality service when first quality is possible, then all of us, working in public and private agencies, must move ahead together on a program of expanded health and welfare services and of research in child life NOW.

For a child, it is bitter economy when we are too late with too little. Help for children must come soon. They have only one childhood to live, and the years are short.

Katharine F. Lenroot

Chief, Children's Bureau

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Katharine F. Lenroot, Chief

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the CHILD

U. S. SUPERINTENDENT OF DOCUMENTS
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A NATIONAL CEREBRAL-PALSY PROGRAM

SAMUEL M. WISHIK, M. D.

Director, Bureau of Child Health, New York City Health Department

WHAT are we doing about the combined health and education problem of children with cerebral palsy? How well have we developed in our country the basic services that are concerned with the health and education of all children and that must be called upon if the special needs of the 150,000 cerebral-palsied children under 17 years of age can be adequately met?

Of the nearly 3,200 counties in the United States, one-third do not have an organized full-time local health department, and many of the remainder have inadequate public-health programs. One-half the counties do not have a single school physician and one-third do not have either a physician or a nurse doing health work in the public schools. At the last compilation, the average expenditure by our States for school health was 79 cents per child per year. One State spent as little as 2 cents per child per year.

We must consider what figures like these mean for cerebral palsy. The services needed by cerebral-palsied children have been recounted many times. The list of specialties involved is long—pediatrics, orthopedics, neurology, psychiatry, psychology, social work, nursing, occupational therapy, physical therapy, speech instruction, and others. The list of necessary resources likewise runs the gamut—clinics, diagnostic services, hospitals, convalescent homes, residential schools, day schools, institutional care, and others. In response to such a description a legislator or taxpayer might well ask: How can we afford that much money? And how can we spare the personnel?

To answer the question on money—in terms of cold dollars and cents we cannot afford to go on as we are, with children unnecessarily institutionalized; adults without remunerative employment, dependent on the community for support; tens of thousands of cerebral-palsied citizens, a tremendous potential reservoir of mental and physical resources, not contributing their capacities to society.

The wealth of a nation rests in its people rather than in its land, its forests, its minerals, or its rivers. Man-built Boulder and Grand Coulee Dams and TVA are converting waste areas into productive land. The Palestinian desert will some day turn into fruit orchards.

Our wealth is the net result of the accumulation of individual contributions—physical, mental, inventive, constructive, social, and other contributions minus the accumulation of drains made on society by some unfortunate individuals through illness, unemployment, or maladjustment, and by destruction, whether the method of destruction be individual or international. Our cerebral-palsied must be taken out of the debit column and placed on the credit side where they belong. They are a sound investment.

There is a way now whereby every taxpayer feels the pinch and realizes very clearly that he pays in the end for not paying in the beginning. Although we, unlike some primitive societies, do not kill off our members at 40 years of age, until recent years the care of old people was anybody's business. We did not think of making systematic allowance for security in old age. With our increasing acceptance of government responsibility for old-age security, we can now measure in dollars how expensive it is to have so many of our total adult population unemployed because of physical handicap, not contributing even payroll deductions toward the care that society will have to give them in their later years. The rest of us pay for this care.

Aside from the cost, the question is often asked: How can society be expected to take vast numbers of especially trained and experienced personnel and such extensive facilities and set them aside exclusively for cerebral palsy? The answer is that we cannot and should not.

That may be a strange thing to say. Isn't cerebral palsy a tremendous problem? Yes! But the cerebral-palsied person does not have to be removed from society and set off by himself in order to get all the specialized care he needs.

Just because a given cerebral-palsied child needs a special clinic for diagnosis does not mean that that particular child necessarily needs specialized schooling or a separate approach to his other needs. And just because a certain cerebral-palsied child at 8 years of age is found to profit from a special class in elementary school does not mean that he will not adjust excellently in a regular class in high school.

Do not isolate the cerebral-palsied

The cerebral-palsied person must not be stigmatized as being so different that he cannot belong to a general group, that he cannot attend regular activities, and that he cannot receive service from specialists who are working with other problems as well as with cerebral palsy.

Our community services are organized in two ways, by functions and by population groups. As an illustration of the functions, we have schools for education and hospitals for sickness. As for population groups, we have schools for children and separate schools for adults. Sometimes we go too far in developing separate services for certain groups of people, such as having two hospitals side by side giving the same kinds of service. Too many of our activities are wastefully set up in duplicate fashion for different population groups.

We must try to strike a better balance between the two methods of community organization on the basis of convenience and effectiveness. We must remain flexible in our planning.

If we can first locate the cerebral-palsied children most effectively by having a general clinic for all children who have trouble walking or using their hands or talking—then let us have a general clinic for case finding.

If we can get the best kind of specialized diagnosis for cerebral-palsied persons by means of a special cerebral-palsy clinic, such a clinic should be set up.

And, after specialized diagnosis, if we have in a school five cerebral-palsied children who need speech instruction, and there are half a dozen others who have cleft palate, or who stutter, then we set up, not a cerebral-palsy class, but a speech class. And if in the school there is a small number of cerebral-palsied children who need daily physical therapy, and several other orthopedically handicapped children who could profit from physical therapy, then, under medical supervision, let us offer physical-therapy services in that school to all the children who need it—regardless of diagnosis.

Obviously, we have a better chance of getting special speech instruction or physical therapy for the larger number of children and for the different kinds of needs. And it is better that way for every reason. For the cerebral-palsied children then have a chance, even in the special periods, to mingle with other children. And it is good for the others to get to know the cerebral-palsied children. For the teachers and other professional workers, it is wise to devote somewhat less than 100 percent of their time and study exclusively to cerebral palsy. Constant comparison between children with all types of handicap or with no handicap is good practice for the professional worker.

In our community structure special services are built upon the general services and depend upon them. A complete battery of personnel and facilities is not repeated for each diagnostic condition—for rheumatic fever, for poliomyelitis, for cerebral palsy—separate nurses, teachers, doctors, except for that period when the children need them. The rest of the time, the same children need good general services—good general education, health supervision, and so forth. In such a setting, cerebral-palsy services once established are most likely to survive and to flourish.

This does not mean, however, that there is one rigid sequence or priority of development. We must not necessarily wait for the perfect school system and health service before developing a cerebral-palsy service. Good speech instruction even with little else is valuable; good medical care without special education is a contribution, though weighted in one direction. Whichever component is established, however, must itself be on solid ground. To illustrate, physical therapy must have qualified medical supervision; special school placement without medical diagnosis is obviously improper.

How special services grow

Having good basic resources will not automatically produce a cerebral-palsy service. Our experience to date shows us how long the very best of our communities went without attempting to meet cerebral-palsy needs. As a matter of fact much of our growth in this direction does occur in somewhat reverse fashion. Scattered local school systems institute special services such as a crippled children's class, a speech teacher, or a remedial-reading teacher. Soon the State department of education finds it necessary to give a label to the special services, to set aside or earmark funds for them, to establish standards and curriculum information and to give supervision and consultation to them. Now 34 State departments of education have directors for education of exceptional children, many of which resulted from grass-roots development.

It is clear that a simultaneous attack of two kinds is therefore necessary—the general and the specific. While we give every possible support to strengthening our basic community resources for health and education, we must at the same time work for developing spe-

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cial programs, and then we must try to get each component of the special program such as speech teaching or health supervision in the school strengthened, extended, and finally generalized.

A striking example of this dual approach is in professional training. The greatest single obstacle today to adequate care for cerebral-palsied persons is the lack of personnel trained and experienced in cerebral-palsy work. If today we had at our disposal all the funds we wanted, we could not immediately make an appreciable dent in the problem. We would first have to concentrate on training doctors and other workers. Nor would we find professional schools ready, equipped, or financially able to absorb the student load we would want to place upon them. Therefore, those who are interested in development of better cerebral-palsy services must not only give aid to the training of certain individuals to come back to work in their own community service; they must have a special stake in moves to give public support to medical schools and other professional teaching institutions.

There are obvious reasons for stressing the role of government in the problem. First, because government is responsible for the two basic services, education and public health. In both services, our horizons have widened in recent years.

Educational authorities do not limit themselves to saying, "Here are the schools for your education; come and get it if you can." Educators now accept the responsibility of making education truly available to every child, if necessary by means of special transportation and classroom equipment, by lip reading for the deaf, and so forth.

Cerebral palsy not an individual problem

Likewise, public health has attained a broader outlook. In earlier days, its interests were impersonal ones, such as epidemics and sanitation of water and milk supply. Today we believe that our public health is the net total of the good health or lack of good health of all our 140,000,000 individual citizens. And cerebral palsy is a public-health problem. It is not an infectious disease, but like such a disease it affects more than the patient himself. It limits the happiness and productivity of the other members of the family as well as of the patient, and it makes demands upon the time and efforts of professional workers.

Nevertheless cerebral palsy has not received adequate public support, probably largely because of the cost. Such a program is expensive, true, but how does a government—Federal, State, or local—arrive at the decision that a problem is unworthy of the expenditure?

A short time ago, our Federal Government spent close to a million dollars to rescue 12 men stranded on a Greenland ice cap. Of course they should have been rescued. Of course, the money should have been spent. Everyone agrees. But how many States have indicated that their cerebral-palsied citizens, numbering many more than 12, are at least as worthy of salvage as the 12 in Greenland? And so when a program is disapproved on the grounds of being too costly, it may be that we just have not convinced ourselves and our representatives that these people are worth while bothering about.

A second reason for emphasizing the government's part in the problem is the diversity of services which must be pulled together for cerebral-palsy work. Few hospitals or nonofficial agencies in the country can afford to carry an extensive cerebral-palsy program without financial assistance. And no voluntary group can be expected to develop its programs on the basis of the total community problem or to accept responsibility for all in need. A voluntary organization is compelled to keep its services within its own limited capacity and resources. Every good cerebral-palsy program, no matter how few persons it serves, is a contribution to total success, but we must aim for an over-all plan to meet the various needs of all the cerebral-palsied persons in a community, in the State, and in the Nation. No matter how comprehensive a private or voluntary cerebral-palsy program may be in a community, the government almost always must share the burden and participate in one way or another.

In speaking of the cost of care we have not yet mentioned the family's financial part. Cerebral palsy is no respecter of station or of wealth. It strikes all sections of the population.

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A COUNTY AGENCY TAKES OVER PROTECTIVE SERVICE FOR CHILDREN

DOROTHY D. HAYES, Associate Professor of Social Work, Graduate School of Social Work, University of Utah

WHEN parents are failing to give their children the good care that is their children's right, the community's conscience—written into law—demands a change. Such a demand is not always as difficult to fulfill as we might think. It is often breath-taking to discover the capacity of parents to better the quality of the care they give their children in answer to the community's demand, if they have the right kind of help.

What kind of help can they be given? How can the conscience of a community so express itself that these parents will begin to care for their children responsibly? Perhaps an illustration will answer these questions best—the experience of one community that gave its county welfare agency the responsibility for helping fathers and mothers who are failing as parents.

Taking over a service

The agency whose 5-year experience is related here is the welfare board of a large midwestern county that contains a city of 500,000 people and rural areas as well. Legally this board could have carried out from the beginning the protective service for children. But the law that *authorized* the agency to give the service did not *require it* to use this authority, and up to 1941 a privately supported protective society had been doing the work. In that year the welfare board took over this legal function of protecting children from neglect.

The board assigned the work to the child-service division of the county welfare board. The division was then administering child-welfare services to dependent children whenever the juvenile court transferred guardianship from the parents to the State department of social welfare. That program consisted mainly of foster care. The "intake" work of the division—such as (1) the first interview, (2) making sure the complaint was valid, and (3) deciding about acceptance of the request for service—was separate from the intake work of the public-assistance programs of the welfare board. This county welfare board we shall frequently call, for convenience, "the agency."

The transfer

How was the transfer of the protective service made from private agency to public agency? For 6 months before the proposed date of transfer, announcements of the new arrangement were published in the local newspapers and were sent to the schools and to social and health agencies for children. A small staff, selected from the child-service division and the private agency that was relinquishing the protective service, worked together intensively to choose from the private agency's cases those that were to be transferred to the public agency. The parents of the children whose care was to be taken over by the new protective service were told about it by the private agency workers and were helped by them to understand the reason for the change.

The court worker

Meanwhile plans to strengthen the agency's staff for the taking over of this new function were being made and carried out. For example, a new type of position was added to the staff of the county welfare board, that of court worker. The duties were outlined by the director of the State merit system, with the help of the head of the child-service division of the agency. Later the new position was filled by a qualified caseworker. This worker and the juvenile-court judge both took part in making the preliminary plans for the protective service. They determined how the time of this one specialized worker could be used to the best advantage of the children.

The chief duty of the agency's court worker was to present cases of dependency and neglect to the juvenile court. As time went on, the court worker also served more and more as liaison between the agency and the juvenile court. She also acted as a link between the agency and other courts that frequently heard the cases of men and women whose children's interests were involved. These were the district court, within whose framework the juvenile court functioned, the municipal court, and the probate court.

Because the courts respected the court worker's ability and valued the results she could bring about, she took an increasingly active part in conferences with judges in matters relating to referrals, confidentiality of court records, adoption petitions, and divorce hearings. She was invaluable in explaining protective services to any person whose occupation, connected with courts in some way, brought him in touch with children who might need the services or who were already receiving them. Among these persons were probation officers, police officers, judges, attorneys, and the county sheriff and his staff. She kept open the channels of communication between the courts, the welfare board, and the community.

Looking back

In spite of all that had gone into preparing for assumption by the public welfare agency of responsibility for protecting neglected children, the first 18 months of work (January 1942–

September 1944), considered in retrospect, was a period of trial and error. The program-building eventually succeeded, however, because of the deep and active interest of the key persons in the county agency, including its board, its executive, the heads of all its service divisions, and the whole staff of its child-service division. All wanted very much to give the community the best possible protective service; they realized that developing such service takes time and energy, as well as money.

Toward the end of this preliminary period, deficiencies and mistakes became apparent. What changes should be made? Too much responsibility had been given to untrained and inexperienced workers on the welfare board's staff. Policies and procedures were not carefully enough thought out and were still unwritten. No clear distinction had been made between the activity of the intake service and the work that followed, nor was the value of this differentiation recognized. As a result, intake workers found themselves bogged down by a load of protective-service cases, carrying some of them for months.

Large numbers of persons with an interest in civic matters who logically would be interested in backing this service were not taking their laymen's share of the public agency's new responsibilities. Their support was needed. Questions were arising whether the county welfare board was protecting children in a responsible way, and no one seemed to know the answers.

The agency rebuilds

At this point the county welfare board did some reorganizing. It defined the protective service's field of activity and the responsibilities of the intake workers for that service. To a supervisor and three qualified caseworkers from the staff of the child-service division were assigned the duties of interviewing all who came to the agency about children and of deciding what the next step was.

The welfare board also set up in the child-service division a separate unit for the protection of children who were being neglected or abused. It consisted of a supervisor and five workers, and it worked closely with the other units of the division. The board set up, in addition, a personnel division to serve the whole welfare board. The director of the division was a qualified caseworker who also was trained in personnel practices and in administration. The personnel division worked out procedures that resulted in the selection of workers who were truly suited for the tasks they were assigned to do. Each applicant was interviewed by the personnel director, of course, but also by a division director and then by the unit supervisor who was specifically concerned with the vocational background of the applicant and her immediate work interests. This screening benefited the protective-service unit particularly, because it needed workers with a special skill and ability.

Out of the first 2 or 3 years of experience grew the theory and practice of protective service that will be discussed here. The growth during the first years, stimulated by the welfare board's willingness to evaluate, discuss, and clarify its services, and to try out new ways, gave the case workers in the child-service division a valuable job experience. It was they who had to meet and solve in a practical way, step by step, the problems presented.

Establishing procedures

What are some of the problems of procedure? We might take up four as examples: (1) Who is regarded as the "client," when help from the agency is first asked for children who seem to be in danger or to be suffering from too great hardship? (2) How does a worker first approach parents when a complaint has been made against them—in fact, what is the flow of activity from the moment the request for action is made to the time when the worker and parents are in the midst of their effort to change conditions for the children? (3) What is the relation of a protective service to other services for children? (4) What use is made of the juvenile court?

Who is the "client"?

In developing a protective service, the child-service division came to regard as the "client" the person who makes the complaint, the person who is concerned enough about the well-being of some child to try to get help for him. He is the person who is willing, after talking to the intake worker, to carry on further if necessary. That is, he is willing to do more than telephone and say: "You must do something about this right away." He sees that he will be needed for certain information and action, that if he is really expressing the community conscience he will accept an active part in that expression. The worker may ask him in the first conversation whether he is willing to be interviewed at greater length at his office or home or at the agency's office, so that he and the worker may talk over his report about the child and the responsibilities of each in efforts to help him. The worker may ask the client whether he can give the name of the family responsible for the care of the child, and the child's name, and tell what school he attends. Has the client seen any instances of neglect or abuse? If not, has he evidence to support his belief that the child needs help? Would he be willing to testify in juvenile court if court action became necessary?

This last question springs from the right of a man accused to face his accuser in court. The responsibility rests with the agency for initiating court action when it becomes clear that no other action will bring about the well-being of the children. But it is the policy of the welfare board to refrain from revealing the identity of the complainant without his consent; hence the question.

In actual practice, this question became less and less frequently needed because, as the work gained in effectiveness, the court was used only under special circumstances. Protective workers were convinced that the plan to take court action is soundest when the parents and the worker agree on it. Workers try not to use court action as a last resort, but rather to use it as a vital part of protective practices—the community expressing in law its standards of child care. Constructive use of the protective function begins with the conviction that parents can change from acting irresponsibly toward their children. Parents can use the protective service when they are given time and help.

Opportunities at intake

When the person making a complaint first discussed the child with the agency worker, he did not have to give all the items of information needed. If he could give a few of them he and the agency could begin action. But discussion of the situation from the very first moment of complaint gave an opportunity for explaining the service so that the person asking for service (often it was another agency or an institution) would pass information on to associates. Understanding the principles of the work, the person or agency referring the child for service would then have enough confidence in the agency to allow subsequent action to rest with the protection worker and the parents.

Requests and responses

When a complaint was made, the intake worker explained, if necessary, that the protective service could not punish parents—nor did it wish to; it could not adjudicate them as "neglectful," as it had no judicial function; it could not—nor did it wish to—remove children from their homes without the consent of their parents or without a court order. The worker made it clear that quite a bit of time might elapse before the parents, even with help, could better conditions for their children. She pointed out that it was logical to allow a reasonable time because it had taken time for the situation to become as bad as it was. However, a limitation would be set on the amount of time the parents could have to bring about a change. Also the parents must give their children increasingly better care during the time the full change required was becoming a reality.

If a father asked the agency to discipline his wife because she was neglecting their children, the intake worker could explain to him that the service had no way of forcing his wife to be a better mother. But, the worker might say, if he and his wife wanted to know what the service could do, or about any other service for children in the community, the worker could give this information. Help for perplexed parents was possible to get.

When a mother came to the agency because her husband had deserted the family, the intake worker explained that the agency, having no police power, could not bring her husband home. But the worker would let the mother know that she, the worker, understood how difficult it is for one parent to bring up children alone and that the agency did have services for mothers and children when the father was absent from home. If the mother wanted to know more about these services the worker could see that she talked to the right person about getting them.

When a mother had deserted her children, the worker could say to the father that the agency had no authority to bring his wife home but there were other services that he might want to use. He might want to discuss the possibility of temporary foster care for his children while he was making permanent arrangements. If not, perhaps he could use the homemaking service of the family-service society (a privately supported agency). That service would make it possible for him to keep his children at home. While he worked they would be cared for by an experienced homemaker, supervised by the society.

The intake worker could say to neighbors complaining about small matters that the county welfare board could not mix in neighborhood feuds and to unreasonable relatives that the board could not mix in family squabbles. And so in a multitude of ways, day by day, the protective service explained itself to those who came to its office. It recognized valid complaints that were within its power to accept and work on, it explained its limitations, and it told of services besides its own that might help. Thus, at the initial interview it showed something of the community's standards of child care.

Only a sure foundation

Early in the development of the protective service the staff realized that unless the work from the first moment of the complainant's contact with the service was sound, later work with parents was unlikely to bring results. The work of other units of the child-service division—for example, the placement unit—could not be sound unless it was built on a sure foundation, laid in the first interview. Child care must be a continuing process, but there can be and must be a distinction made in the functions of intake, protection, and placement.

Starting the work with parents

Having considered the first contact of the client with the protective service through its intake unit, let us see how the worker of the protection unit starts to work with parents. She begins only after an intake worker has substantiated the complaint as valid and the agency believes it has the legal responsibility to make the complaint known to the parents. At this point the supervisor of the protection unit takes over the responsibility. She might later confer about the situation with the intake unit, just as she does with the head of the child-service division and the court worker and, on matters of policy, with the executive director. By recognizing what methods are getting results and what methods are not, these conferences, while considering what to do in an individual case, clarified and defined methods of giving protective service, and suggested ways of improving them.

The letter to parents

One procedure that grew from experimentation and from conference discussions was the sending of a letter to parents as the first contact. This letter—not a form letter—told them that a complaint had been made about the situation their children were in and asked the parents to come to the office for an interview. The letter set forth the complaint in detail and described the protective service available to the family. It gave definite information to help in making an appointment—the agency's telephone number and the name of the worker to ask for.

This letter proved to be helpful to parents in spite of the bitterness or anger it sometimes aroused. Rarely did the letter fail to get a response. It gave the parents something definite to think about, something upon which to focus their fear or their anger. Many parents came for their first appointment with this letter in their hands, some to unfold it nervously at the start of the interview and to leave it at departure on the desk of the worker. Others waved it angrily in the face of the worker and then in the end folded it carefully and tucked it away in purse or billfold. From responses to the letters the workers learned a great deal of what to expect from parents in that first interview. But more important, they learned to help parents to understand their feelings about the letter and about coming to the agency. Such understanding laid the foundation for under-

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HOW WE TOLD OUR ADOPTED CHILDREN

KITTE TURMELL

WE have had the good fortune—my husband and I—to adopt two children, each in infancy, 3 years apart. We have been able to tell our son and daughter—successfully we think—without strain or self-consciousness—that we adopted them. Our son, the first adopted, very soon heard the word "adopted" in improvised lullabies; when he was 2 he was proud to translate its meaning as "you picked me out"; at 3 he joyfully went with us to the nursery on the day when we were at last to take home his newly acquired sister.

How did we know what to say and when to say it? By asking advice of the social agency that found our son for us, as many other parents of adopted children have done. Ours was the Children's Home Society of California, a State-licensed private organization. A staff member of the agency suggested something like this:

The story of adoption should start as soon as possible. A baby can be helped to feel that "being adopted" is something that makes him loved, even before he is old enough to learn that being adopted is being "chosen." The story of his adoption should unfold as his understanding unfolds. When the story unfolds gradually, and is pleasantly told, he will think of it as natural and pleasing. He will look at it just as the parents do who have gone through the experience of choosing a child who is to be theirs for life.

The story starts with the way you say "adopted." If the word is used often, affectionately, easily, with an endearing phrase or a song or a nursery rhyme, and emphasized with a hug or kiss, it will carry warm overtones. It should never be heard first as a playmate's taunt or an adult's whisper.

As soon as a toddler asks, "What's 'dopted, mommy?" he is ready for an explanation of "chosen" or "picked out." This can be made personal, as a compliment to the child's desirability, with the phrase, "We chose—or picked—or wanted—*you*."

The age at which a child is old enough to be told more about it varies with different children, the worker told us: it is usually between 3 and 4, and certainly before school age. Whenever he does ask, or is ready to be encouraged to ask, tell him simply as much of the story as he can then follow. If you repeat it, and amplify it a little as his interest grows with his capacity to understand, he can enjoy this true story as much as he does a favorite fairy tale.

"To be our very own for always"

But say it *your own way*, the social worker's advice continued, using as much as you like of this suggested version: For a long time we wanted a baby just like you. We were lonely; our house seemed empty. Then someone who knew where there were some babies who wanted mommies and daddies helped us find you. You were bright and lovable and beautiful, just as you are now. You were the baby we wanted, so we brought you to your new home to be our very own for always.

Saying it "your own way," of course, gives parents a chance to use various ways of telling the story. We, for example, decided to add pictures to the words to illustrate the story of the adoption of each of our children. We framed snapshots taken on each of the two christening days. These pictures showed my husband, proudest of fathers, beaming as he holds the newly named baby. They are on the wall of our breakfast nook, where our children can see them easily. They admire them again and again, beaming themselves at the pride and joy they see in Dad's face as he looks down at his adopted son or daughter.

That is one of the things that my husband and I did. I'd like to tell you about what other parents of adopted children have done.

Karen's mother made a scrapbook from many-colored sheets of heavy paper. She typed in "the story," using for illustrations snapshots and pictures clipped from magazines. For the chapters of the story after baby Karen was settled in her new home, the illustrations show such daily rites as feeding and bathing the baby. The pictures were selected to show what fun the family has bringing up baby.

On every page of Karen's scrapbook are stories or pictures that show the little girl that she is loved. A page representing her first Christmas, showing Karen with her new toys, is captioned, "Santa Claus brought you a dolly and a tree. Your mother and father got fine presents, too, but the best gift they could ever ask for arrived before Christmas . . . that was KAREN."

One present to David's parents when they adopted him was a baby book, with places to enter facts about the new baby. Some of the entries asked for were inappropriate, such as birth details. And so David's mother and father converted the book into an "adopted-baby book" by pasting over the inappropriate pages new hand-lettered headings and by using the blank pages in front for a biography that begins: "David is a chosen baby. He was born on November 8, 1945, but he was almost a year old when we, his parents, chose him for our very own." A page headed, "My Adoption Day," contains a happy account of the visit to the judge—whose decree made the adoption legal. This is illustrated by a snapshot of a happy family of three. On another page is mounted one of the "proud-to-announce" adoption cards that were mailed out to friends and relatives.

Bonnie's parents also used photographs to help her understand her story. One is of the parents on their wedding day. The other is of the family of three, including Bonnie. These two pictures are used to illustrate a legal point—that just as Bonnie's parents were not "related" until they chose one another for marriage, Bonnie was not related to

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Parents who have adopted a child often ask a children's worker to advise them about telling the child what he needs to know about his adoption. To help workers who are asked for this kind of help we are publishing one adoptive mother's account of her experience.

them until they chose her for adoption. The legal relationship that is created by marriage or by adoption, they wanted the little girl to realize, is just as strong in its way as a blood-relationship.

June's mother wrote a diary about June's arrival and progress, beginning with the parents' pleasurable anticipation of the little girl's coming.

Paul's father told the story of Paul's adoption on a home-recording machine, improvising a nursery-tune accompaniment.

Judy's mother wrote the story of Judy's adoption in a "Dear Daughter" letter, illustrated with many amusing sketches. This she put with Judy's third-birthday presents, with the idea that it would be read aloud to the child after the birthday excitement was over.

You might use ingenuity, as these parents did, in telling the story of adoption, or you might just tell the story in a straightforward way. What really counts, says the social agency that is helping us, is your calm sincerity in explaining the facts and in answering questions.

Invite discussion, but don't overdo it

Some further guides that the agency has given us are as follows:

Do not wait indefinitely for a cue for giving more information. If necessary, spur the child's curiosity by referring to the adoption when talking to someone else in the presence of the child. He might have forgotten the word or might be hesitating to ask.

Explain and repeat as often as necessary to assure that he understands. However, do not overdo the open-discussion attitude with unnecessary repetition, which could make the child overly conscious of being adopted.

Open the door to easy discussion in the future by encouraging the child to feel free to bring up any matter that puzzles or troubles him at any time.

Do not exaggerate the superiority of being chosen over being born into a family to such a degree that the child boasts to others. This might set him apart from his own group.

Do not precipitate questions that might never arise.

Do not overestimate your child's understanding by giving information too complex for him, but do not underestimate his ability to grasp the idea of adoption. (It might be later than you think.)

So far, our children, both still under school age, accept the idea of adoption as naturally as they do their names, their looks, and where they live. We are ready for the questions they will ask in the future, once *they* are ready for the sex education that will give them their first insight into the difference between blood and legal relationship.

When we talked this over with the agency worker, she reminded us that no child really understands adoption until he has some idea of conception. Soon after a child enters school, often at about the age of 8, he will ask where babies come from, and then, where *he* came from, the worker continued. That is the time when you explain that all babies are born in the same way. Some, however, are given to new parents some time after they are born.

"Who?" and "Why?"

When the child knows how babies are born the inevitable question will come: "Who was the mother who *did* carry me in her tummy and why didn't *she* keep me?" This is the signal for the explanation, the worker said, that a mother and father entrust a child to another mother and father only because they believe that in this way they can assure a better life for the child than they could give him.

If a child keeps on being curious about where he was "found," said the worker, give him an enthusiastic description of the hospital, or social agency, or nursery, at which you first saw him. Tell him how he looked, how he held up his hands to be taken to his new home by his new parents.

We know that *our* children enjoy this. They like to listen to a description of the nursery home's reception room, in which we first saw each of them, smiling and kicking in a pretty bassinet.

The worker told us that two-thirds of all adoptive parents in the United States, according to surveys, wonder sometimes how much to tell the child if his desire for details about his natural parents becomes stronger as he matures. This is no serious problem for my husband and me. We are pleased about our children's life histories, and we want to tell each of them as much as possible—at least, as much as seems advisable at any given time. This, of course, depends upon the degree of their interest. We are following this advice from the California society:

Be logical and truthful in whatever you say. Do not parry a specific question with a vague answer.

If there are any could-be-disturbing

The youngster's playmates should never be the first to tell him that he is an adopted child.

factors that need to be told, bring them out early, and gradually; when a child grows up knowing the essential facts they will become as much a part of him as his build or his voice.

Give as vivid a word picture as you can about his natural parents. Often curiosity is easily satisfied with a pleasing description. Tell what the child seems to relish, but do not build up such a fascinating picture that the child will feel robbed when he compares, in his imagination, his natural parents with his adoptive parents. He should not be given the feeling that he has been deprived of a more interesting life or a more colorful heritage than you, his parents, can offer him.

Do not let your child feel isolated by his adoption. Talk with him about other adopted people he knows about or that he can be introduced to in normal social contacts. If his national background is different from yours to a marked degree, see to it that he is helped to like and respect "his own kind." He may learn about this background at school, or through his reading, or through other association with the culture of his forebears. Perhaps he will find out more about it through travel.

Satisfy the craving of every adopted child to be told that he bears some resemblance to his adoptive parents, or to some other relative whom he would like to resemble. Often environment develops similarities that you can point out by identifying "his mother's ready smile" or "his dad's dependability" as a characteristic shared by parent and child.

School the child against any future embarrassment from prying questions by explaining that he may tell as much or as little as he chooses about his adoption story. Help him to realize that he can be proud to tell anyone that he and his parents are more than satisfied with every detail of his history.

Long ago my husband and I learned that we also could ward off impertinent questions (and you'll be surprised to know how many strangers are bold enough to ask whether the adopted child's first parents were married.) We say that we want the child to be the first to tell his story to outsiders, in order that he may tell as much or as little as he chooses, without feeling, uncomfortably, that others might know more than he does about his personal history.

Perhaps the keystone of the arch through which the child enters into knowledge of his history is this principle, as stated by the children's agency:

"You must guard against projecting any emotions that might disturb the child about his adoption story. He will be influenced by your attitude: aware of any tension or uneasiness. If you are afraid that the child will not accept his true story, then you, his new parents, need to reexamine your heart, rebuild your feelings of security, refresh your mind on all the favorable factors that convinced you before the adoption that this was the very child for you. Until you have quieted any qualms of your own you are not emotionally ready to start the continued story we are here considering. If you do learn to tell the story well, your reward will be your child's acceptance of his adoption and of you.

CEREBRAL PALSY

(*Continued from page 100*)

Some wealthy families are able to pay all costs. But how many other families are there, even the comfortably situated, who can carry the costs of years of service from physicians, speech teachers, and physical and occupational therapists, in and out of hospitals? Very few can do this. Therefore, the benefits of cerebral-palsy programs as they are developed should be made available to all, regardless of their economic status, and parents should be given a chance to pay what they can afford, without pauperizing themselves and also, without depriving themselves and their other children of the necessities and reasonable pleasures of life, and in full recognition of the limited vocational opportunity and earning capacity that will face some of the cerebral-palsied children when they reach adulthood.

Another very important contribution to the battle against cerebal palsy is the association of interested citizens. It is largely through the work of citizens' groups that interest in cerebral palsy has increased so much in recent years and that new programs have been begun in various parts of our country, in Canada, in England, and in other parts of the world. Part of the strength of these citizens' groups lies in the fact that they are composed largely of relatives of cerebral-palsied persons. Because of their own personal experiences in futile searching for adequate care, they have the kind of zeal and stick-to-it-iveness that gets results.

Plan next steps with care

From now on, however, that special strength—their immediate personal investments—may become a weakness in citizens' associations. The first obstacles in our path have been overcome. The general public is getting interested in cerebral palsy, legislators are more sympathetic, the professions are becoming increasingly cognizant of it. More programs are waiting to spring up on all sides. The period ahead demands careful planning and sound community organization. Programs should be developed on the basis of over-all need, of effective integration with existing facilities, and of likelihood of good results. A citizens' group should encompass a broad base of the community, including both lay persons and professional workers. Parents of cerebral-palsied children and adult cerebral-palsied persons themselves will and should continue to be among the leaders and to bring to the groups the benefits of their experiences, whether bitter or pleasant, and of their strong conviction of the tremendous importance of the problem.

But there will be times when the best sequence in adding new components to a community cerebral-palsy program will require giving service sooner to one group of cerebral-palsied persons than to another; such as to preschool children before school-age children, or vice versa, or to the work of vocational aid for adults rather than speech instruction for children. The time table of the steps will differ from place to place, but the goal of a full, comprehensive program is the same for all. Parents will at times find themselves in the painful position of supporting their citizens' group in sponsoring a program which helps another's child, not their own. That is not at all easy, but at first it must be done. Broadening the composition of the citizens' groups will temper the decisions of the group with more objectivity.

On occasion, an entire lay association will properly support a community decision to postpone the actual giving of service until personnel can be trained. Here all the cerebral-palsied persons will go without care for a number of months or even years while the association helps to send the future cerebral-palsy workers away for training.

There follows here a seven-point national cerebral-palsy plan. This plan is a practicable one which can be started now—and not a fantasy for a decade or two hence.

1. Stronger school systems in all States, with adequate special educational programs for handicapped children and training programs for special teachers.

2. In every county in the Nation, full-time organized local public-health services.

3. Expansion of school health activities and crippled children's services. Establishment of cerebral-palsy programs as rapidly as is feasible and of training centers for cerebral-palsy workers.

4. Establishment of a national research center on child life.

5. Expansion and coordination of research on the causes and management of cerebral palsy.

6. Aid to medical and other professional schools so that larger numbers of better-qualified professional workers can be trained.

7. Enlarging the membership of citizens' associations working for improved cerebral-palsy care; and support by the associations for community education, professional training, scientific research, and services for cerebral palsy. Participation of the citizens' associations on joint councils and on advisory committees of official agencies at the Federal, State, and local levels.

Attainment of this program would establish both a solid community framework and sound special services for the well-being of our cerebral-palsied citizens.

PROTECTIVE SERVICE

(*Continued from page 103*)

standing their feelings about their children and about themselves as parents.

The core of the work

The service offered to parents, which began with this first interview, can be briefly stated in this way: In giving the service, the agency aims to show its feeling of respect for the dignity of each person who comes and to let him know that the workers do not disapprove of him because a serious complaint has been made against him—a complaint that he is failing to care adequately for his children. The agency emphasizes the fact that the fathers and mothers complained against are expected to become better parents by all in the community who are interested in all children. And it emphasizes its belief that they can change. The worker's skill is brought into action for the very purpose of helping them, as they learn to use the protective service to improve conditions for their children. The protective service shows its confidence in a parent's capacity to change.

Each parent has his own emotional responses to authority, which he can be helped to understand. He will test this authority again and again, only to discover that it is one of the most dependable forces he has yet encountered. His struggle to make use of this authority—often a deeply felt experience for him—can result, and frequently does result, in a reorganization of his pattern of behavior. It may bring about a change in his emotional responses to what happens to him and in his attitudes and his actions. This change makes it possible for him to give his child the love the child has been without, and to give him the benefits that result from parental love.

A link with other services

A year after the reorganization, the staff of the agency appreciated fully the need to keep close to the community and to encourage professional and civic groups to keep close to the agency. The case work committee of the local council of social agencies provided one way of creating this necessary interrelation. This committee held biweekly meetings for nearly 2 years to discuss the intake policies of all the agencies that came in contact with inadequate child care. By hearing case material discussed, members of this committee learned what situations to refer to a protective service, what the court worker does, how the protective service uses the juvenile court, and how the protection worker goes about her service to children and their parents. Many other groups besides social casework agencies were invited to send staff members to the meetings. That meant that teachers, probation officers, policewomen, church workers, public-health nurses, and members of parent-teacher associations were present to learn about the service and how protection workers could use the skills of other workers.

A study results from discussions

One of the tangible results of the biweekly discussions was a study of a number of cases of parental neglect, made in order to throw light on certain aspects of the problem. Among the points the committee studied were this new relation between protective service and parent; the length of time that is reasonable to allow for agency and parents together to change the conditions that are harming the children; the factors in a situation that determine if the case is one to refer to a protective service. It also tried to determine whether the county welfare board was administering this service well; that is, whether it was acting as the conscience of the community vigorously and sensitively.

The findings influence public opinion

The study itself, besides supplying valuable information, had the tangible result of influencing community thought about the effectiveness of the local protective service. That is, the feeling of many persons and agencies already interested in children changed from uncertainty to certainty. Most of the members of the committee, and an ever-widening circle of agencies and individuals, did come to believe that the public agency was indeed making headway in improving the lot of a very helpless group of children and parents. The people of the county wanted better care for children who were in danger because their fathers and mothers did not know how to be good parents. They delegated to the public agency the responsibility of bringing about this better care. The county welfare board believed that parents were the ones to give this better care, and that the board's task was to help them succeed but to safeguard the children while the required change was being accomplished.

Relation of the agency to the court

Without a solid bridge between the juvenile court and the agency responsible for safeguarding children who do not have the right kind of care, there can be no protective service of the type discussed here.

It was clear to all concerned at the time of the agency's reorganization that the protective responsibility of the agency is different and distinct from the court's authority. Agency and court are independent of one another. Just as the court is not an arm of the agency, so the agency is not an arm of the court. Each has a right to expect the other to make its referrals of children in accordance with the agency's or the court's procedures. In this county, responsibility for treatment in juvenile delinquency cases rests with the court, which has its own probation office for that purpose. The agency, therefore, does not accept referrals of children who have been adjudicated as delinquent.

What seemed only a matter of using terms correctly might raise points about the court's authority and the workers' attitudes. For example, the term "neglect" is legally defined, and only a court can adjudicate parents as "neglectful." However, when workers of the agency considered fully all that lay back of that fact, they realized that they needed to change their way of thinking about the parents with whom they worked. It was clear to the workers that before court action was taken—and afterward as well—they ought to think of the parents not as neglectful mothers and fathers, but as persons who were having difficulty discharging their responsibility as parents.

The worker's part

In a service that has authority connected with it, it is not easy for an untrained, inexperienced worker to differentiate the behavior of a person from the person himself. But a caseworker who is qualified by professional education and experience to use this authority and who is accountable to the community for its wise use is able to make this distinction. A worker who cannot feel and express this distinction is apt to increase the fear, hostility, anger, and hate that the parents feel—emotions already brought about by what has happened to them previously. Unless a worker accepts the fathers and mothers as persons with a problem to solve, accepts them sincerely, frankly, without blame, the parents may see this new relation as another blow to their dignity. The worker must know how to give them a chance to express their best selves, by treating them with warm interest and unfailing fairness. When a parent is sure of this interest and dependability, is sure that he is regarded as a person whose thoughts, feelings, and attitudes can change for the better, a change can begin. Knowing that he, himself, is not blamed, even though his behavior toward his children is thoroughly disapproved of, he can begin to improve that behavior through a force that he finds within himself.

Deciding about court action

As court and agency worked together, the caseworkers on the agency staff began to appreciate the value of the court to their work with parents. They came to see more clearly what was sound and what was unsound in their use of the court.

The step-by-step preparations before asking the court to help *the agency and the parents* to protect the child more fully were painstakingly analyzed by the agency. As we have said before, the agency considered it soundest to use the court when both the parents and the agency agreed on plans for which they needed the court's assistance. As experience sharpened the worker's skill, instances became rare in which the agency felt that only the authority of the court would activate the parents to change conditions for their children.

Only infrequently did the agency decide on court action without the parents' having a part in the plan. When this had to be done, the worker took the time to explain fully the agency's reasons, to tell the parents what to expect at the court hearing, to point out their right to counsel.

Parents plan with worker

When it was necessary to take court action, the agency usually asked the court for temporary custody of the children, which gave it the right to protect them more thoroughly. Both the court and the agency pointed out to the parents that this custody was to continue for a limited time only and that during that period parents and agency would be working together. At the end of the time stated the parents and agency were required to appear again before the court with plans for consistently better, long-time care for the children. This arbitrary time limit often served, with the worker's help, to spark a sense of responsibility in the parents.

After the court hearing, the caseworker and the parents talked things over at the agency office. They had sat beside one another in court, which gave a parent a chance to express to the worker whatever anxieties, fears, or feelings of relief he had. Because the worker could help the parents voice these feelings and could show that she understood them, parents found it easier to discuss the court hearing. The worker could see what the hearing meant to the parents and could better plan the next step with them.

The court worker on the agency staff presented all the agency's cases to the court. She organized the material that was relevant, assisted protection workers with forms and legal papers, and joined in all the conferences of the protection supervisor and the caseworker regarding the use of the court. Her calendar tallied with the court calendar, and she recorded all court hearings in the agency's case record of the family concerned.

A good working relation between agency and court develops best when the difference between administrative and judicial functions is fully recognized. Understanding this difference, agency and court alike are in a position to appreciate the value of the other's function.

Unfortunately, many social workers fail to realize that constructive use can be made of the authority of the juvenile court and the law. The parent's experience with this authority can be a positive factor in strengthening of personality and in growth of a sense of parental responsibility.

Just as unfortunate is the fact that many juvenile-court judges and probation officers overlook the potentials of casework for helping people. Many in both groups also fail to realize that the casework process can be used to help parents make the most of the experience with authority. The process can be helpful especially when its difference from and its relation to other processes attendant upon court action are clearly understood.

The profession of social work is actively engaged with problems arising from community needs and with promoting the sound and clearly defined organization of social agencies that have been developed to meet these needs. The processes of casework, group work, intergroup work, and administration can be helpful in integrating community strengths in proportion to the capacity of the community and of the profession of social work to make use of one another.

A profession is courting failure if it attempts to function unrelated to community needs and without the public's general sanction and approval of ways and means. This is true, indeed, of professional services to care for children and to protect their rights.

IN THE NEWS

Nonprofit Monthly Digests Articles on Children

Child-Family Digest, a nonprofit monthly, is being published "to serve all interested in children and family relationship." Its first issue was for June 1949. The editors and publishers are Gayle Aiken Jr., and Charlotte Aiken, 5320 Danneel Street, New Orleans 15, La.

"Square Deal for Every Child" Is American Legion's Child-Welfare Goal

At the thirty-first annual national convention of the American Legion, at Philadelphia, August 29 to September 1, 1949, the Legion adopted several resolutions presented by its committee on child welfare. Three of these, which would be of interest to readers of *The Child*, are as follows:

That the Legion endorse appropriate Federal legislation naming child desertion a criminal offense.

That the Legion cooperate with the American Medical Association, the American Academy of Pediatrics, and other reputable health and medical organizations and agencies in developing a program for improved child health based on community action under community leadership.

That the various units of the Legion be urged to give full publicity to their child-welfare activities, but without exploiting any individual case, and to join other community organizations in the attainment of the Legion's child-welfare goal: "Square deal for every child."

The child-welfare committee introduced its report with the words, "The children of America are its greatest assets, and the Legion is interested in those children. Not only the children of veterans, but all children. We must make certain that every child has sufficient food to be nourished properly daily, and a suitable environment in which to grow into healthy and useful manhood or womanhood. We will not be discouraged by any temporary obstacle that may be cast in the way. The command is forward, and our efforts in conserving our country's greatest asset will be the insurement of peace and prosperity for the future citizens of America."

U. N. Staff Art Show Nets Over $2,000 for Children's Aid

A check for $2,170.57, the proceeds of a 10-day international art show held at United Nations Headquarters by members of the UN Secretariat has been presented to the United Nations International Children's Emergency Fund (UNICEF).

This will make possible the serving of 60,000 supplementary meals to needy children. The UNICEF daily supplementary meal costs 7 cents, of which half is contributed by the assisted government and the other half by the Children's Emergency Fund.

Child-Labor Certificates Protect Both Employees and Employers

Secretary of Labor Maurice J. Tobin has announced the redesignation of 44 States, the District of Columbia, Hawaii, and Puerto Rico as jurisdictions granting age, employment, or working certificates or permits that are accepted by the Department of Labor as proof of age for young workers under the child-labor provisions of the Fair Labor Standards Act. (Certificates granted in these jurisdictions are also accepted by the Department of Labor as proof of age under the Walsh-Healey Public Contracts Act.)

By obtaining State certificates, employers in the jurisdictions designated are able to protect themselves from unintentionally employing under-age children. Employers in the other four States—Idaho, Mississippi, South Carolina, and Texas—have similar protection through obtaining Federal certificates of age issued in those States.

Sixteen years is the minimum age for general employment under the child-labor provisions of the Fair Labor Standards Act. The minimum is 18 for occupations that have been declared hazardous by the Secretary of Labor.

Inspection experience under the Fair Labor Standards Act has shown that less than 4 percent of certificated minors are employed in occupations illegal for the age shown on their certificates. In contrast, 30 percent of employed minors who do not have certificates are employed in violation of the act's child-labor provisions.

For Better Reporting of Birth Weight

In 1950 the birth certificates in all but one State will include an item on the baby's birth weight. This item will provide the basis for valuable information about premature birth, which is now the leading cause of death in early infancy.

A concerted effort is being made throughout the country by State departments of health to obtain accurate reporting of the birth weight of *all* live-born and still-born infants. In most of the States, a circular entitled "Weigh Each Newborn Infant" will be sent shortly to hospitals and to physicians and other attendants who deliver babies elsewhere than in hospitals. The circular urges careful weighing, on an accurate scale, of every infant at birth, including the very small ones and the still-born; and recording of the birth weight on the birth certificate.

The Children's Bureau is interested in the birth weight of babies in relation to a number of factors. Among these are race, sex, economic status, period of gestation, complications of pregnancy and labor, order of birth, and whether the birth is single or plural.

For Better Juvenile-Delinquency Statistics

The Interdepartmental Committee on Children and Youth, a committee composed of representatives of the various branches of the Federal Government concerned with the well-being of children and youth, is circulating to interested individuals and agencies a report of its subcommittee on the improvement of juvenile-delinquency statistics. The report is being sent, together with a letter from Oscar R. Ewing, chairman of the interdepartmental committee, requesting comments and suggestions for improving the collection and uses of juvenile-delinquency statistics. This is an attempt to learn the extent and nature of the interest in juvenile-delinquency statistics on the part of those who use or would like to use such data.

Persons interested in obtaining a copy of the report of the subcommittee on the improvement of juvenile-delinquency statistics may write to Miss Edith Rockwood, secretary, Interdepartmental Committee on Children and Youth, Children's Bureau, Social Security Administration, Federal Security Agency, Washington 25, D. C.

Edward E. Schwartz

• FOR YOUR BOOKSHELF

GROUP WORK WITH AMERICAN YOUTH; a guide to the practice of leadership, by Grace Longwell Coyle. Harper & Bros., New York, 1948. 270 pp. $3.50.

Representing an accumulation of experience in working directly with youth and in teaching youth leaders, this book focuses on problems of group leadership. The author defines the essentials of the group process clearly, and uses case material with skill. She helpfully identifies the different types of groups that a group leader works with, friendship and acquaintance groups, avocational and interest groups, and administrative groups.

The book is substantial evidence that the practice of social group work is maturing and that individual group leaders are seeking objective criteria and means of self-assessment in their professional work.

Juanita Luck

PUBLIC HEALTH IN THE WORLD TODAY, edited by James Stevens Simmons. Harvard University Press, Cambridge 38, Mass., 1949. 332 pp. $5.

The papers presented by a number of distinguished experts in the field of public health at the Harvard School of Public Health during 1947–48, are gathered together in this book, with a foreword by President James Bryant Conant.

Grouped under four headings, the papers cover many of the most important aspects of public health in the world today. The introduction discusses the broad implications of public and world health and reminds the reader that the dreaded communicable diseases have not been eradicated, and that only through the vigilance of health workers are serious outbreaks of these diseases prevented at the present time. Subsequent chapters deal with the growth of the profession of public health and the changing concept of medical practice from treatment to prevention of disease; the development of the great public-health organizations that are carrying the teachings of public health to people throughout the world; a review of the serious public-health problems that exist at present in other countries as well as in the United States; and discussions of some of the problems that have only recently become the concern of the public-health worker.

Throughout these papers, the writers have stressed three facts which every worker in public health may well keep in mind; namely, that while public health has a vast store of knowledge regarding means by which the health of the public can be protected, people must continuously be educated to apply the knowledge; that there are many fields in public health which still remain to be explored; and, lastly, that good health, both physical and emotional, must be brought to people throughout the world as a prerequisite to lasting peace.

This book is up-to-date and authoritative. Since it contains many basic facts regarding health needs, as well as clear statements of the principles and aims of public health, it should be of interest to all workers in this field.

Susan P. Souther, M. D.

CHILDREN IN NEED, by Melitta Schmideberg, M. D. George Allen and Unwin Ltd., London, 1948. 196 pp. $3.50.

In view of the increasing number of social workers who are crossing the Atlantic in both directions to study the child-welfare programs of other countries, it is important that both the visitors and the visited should have as much preliminary understanding of current thought and practice in each country as possible. For this reason Children in Need should be useful to American social workers as a picture of England's child-welfare problems and social-work goals.

Evidently the objectives we have for the improvement of our child-welfare programs are also those of our English friends. We both stress the importance of preserving the child's own home and realize that through skillful treatment the cooperation of even neglectful parents may frequently be gained in better meeting the physical and emotional needs of their children. Planning care for children according to their individual needs and encouraging the development of a variety of institutions to fit these varying needs are the goals of both English and American welfare workers. The training of teachers, social workers, parents, and others in charge of children seems as important in England as it does here. Foster-family care is not as highly developed there as in the United States, but its place in a child-caring program is recognized. State welfare workers in particular will be encouraged to read of the English efforts, similar to their own, to improve standards of institutional care of children.

In both countries it is all too evident that there is great need for more facilities for the care and treatment of children and more sympathetic understanding of children's needs.

Mary S. Labaree

JUVENILE DELINQUENCY, by Paul W. Tappan. McGraw-Hill Book Co., New York, 1949. 613 pp. $5.

This is a comprehensive, well-documented, factual volume on juvenile delinquency, by a professor of sociology and lecturer in law at New York University. It is divided into four parts. Part I deals with the nature and extent of juvenile delinquency, part II with causation. In part III the development, procedures, and functions of the juvenile court are discussed, and part IV takes up treatment.

Part III is especially thought-provoking and enlightening. As the author says in relation to part III, "It is hoped that the reader may be led to recognize both the sociological error of conceiving the delinquent without reference to the framework of legal institutions and the legalistic fallacy of considering him merely as an incident of judicial administration."

The author points out that his approach has been one of "sociological and legal realism." He adds: "Aside from a statement of those ideals which offer some challenge as goals of action, the effort here is to picture practices as they are, not as someone may believe they should be." As a result, some of the practices as pictured by the author do not provide a climate for nurturing a complacent attitude on the part of those who are interested in children and their problems.

In the chapter, The Juvenile Court, the author has the following to say: "The student should realize that the vast majority of children's courts are distinct from the ordinary court system only in having separate hearings; . . . In many places, especially in rural counties, there is little even of lip service to the specialized standards set up for juvenile-court performance. In cities, where juvenile jurisdiction is usually somewhat more specialized, there is great variation also in the conduct of court, much more than in the criminal courts. This diversity is a reflection of the failure thus far to develop any consensus as to desirable goals and methods in dealing with children."

While the author believes that successful prevention and treatment of delinquency depends for the most part on case-work and group-work methods, supplemented by psychiatric investigation and aid, he does point out some of the present limitations in the practice of social work in relation to delinquency.

In the chapter, The Role of Social Work, the author points out the need of coordination and redirection of services by present existing agencies. In this respect he says: "Because of the continuing resistance of many agencies to modification of their intake policies or treatment methods, improvement may come largely through coordination that stresses the initiation of new service agencies to cover unmet needs rather than through the reconstitution of the existing facilities."

About protective services he says: "Protective services for the child represent another area significant to delinquency wherein serious gaps in service exist; the postulate of case work that the client must cooperate and, in fact, ordinarily must originally apply for help means that most neglected and dependent children will not be submitted voluntarily by their parents to the skills of the private case-work agency. If they are, there is real danger that such cases will be discharged as unadjusted through failure of the parents to cooperate. Some voluntary social agencies are experimenting increasingly with protective cases in which they attempt to motivate sufficient parental interest and effort to make effective case work possible. For the most part, however, the child neglected by his parents is also neglected by social agencies until he is reduced to so deplorable an extreme that he is brought forcefully to the attention of a specifically protective agency." The pictures that the author paints of the present practices in the area of probation and institutional care are equally graphic.

William H. Sheridan

• CALENDAR

Feb. 1.—National Social Hygiene Day. Information from the American Social Hygiene Association, 1790 Broadway, New York 19, N. Y.

Feb. 3–4—Community Chests and Councils of America. Biennial conference. Cincinnati, Ohio.

Feb. 3–4—National Conference on Rural Health, Committee on Rural Health, American Medical Association. Fifth annual conference. Kansas City, Mo.

Feb. 6–12—Boy Scout Week. Fortieth anniversary. Information from Boy Scouts of America, 2 Park Avenue, New York 16, N. Y.

Feb. 6—National Children's Dental Health Day. Second annual observance. Information from Director, Bureau of Public Information, American Dental Association, 222 East Superior Street, Chicago 11, Ill.

Feb. 8–10—National Conference of Superintendents of Training Schools and Reformatories [for boys]. Annual meeting. New York, N. Y.

Feb. 11–16—American Academy of Orthopaedic Surgeons. Seventeenth annual convention. New York, N. Y.

Feb. 12–19—Negro History Week. Information from the Association for the Study of Negro Life and History, Inc., 1538 Ninth Street NW., Washington 1, D. C.

Feb. 15–18—American Camping Association. Twenty-first national convention. St. Louis, Mo.

Feb. 17–18—American Academy of Cerebral Palsy. New York, N. Y.

Feb. 19–26—Brotherhood Week. Annual observance. Sponsored by the National Conference of Christians and Jews. Information from National Conference of Christians and Jews, 381 Fourth Avenue, New York 16, N. Y.

Feb. 22–24—American Orthopsychiatric Association. Annual meeting. Atlantic City, N. J.

Feb. 27—Child Study Association of America. Annual conference. New York, N. Y.

Mar. 14–18—Play School Week. Annual conference of Play Schools Association. Information from the Association, 119 West Fifty-seventh Street, New York 19, N. Y.

Mar. 24—National Health Council. Annual meeting. New York, N. Y.

Regional conferences, Child Welfare League of America:

Feb. 27–28—Eastern Regional Conference. New York, N. Y.

Mar. 6–8—Southern Regional Conference. Shreveport, La.

Mar. 16–18—Central Regional Conference (formerly called the Ohio Valley Regional Conference). Toledo, Ohio.

June 5–7—Midwest Regional Conference. Minneapolis, Minn. (Date tentative.)

New England Regional Conference. (Date and place to be announced.)

Area conferences, National Child Welfare Division, American Legion:

Feb. 3–4, 1950. Area B—Delaware, District of Columbia, Maryland, New Jersey, New York, Pennsylvania, Puerto Rico, Virginia, and West Virginia. Atlantic City, N. J.

Mar. 3–4, 1950. Area C—Alabama, Arkansas, Florida, Georgia, Kentucky, Louisiana, Mississippi, North Carolina, Oklahoma, Panama, South Carolina, Tennessee, and Texas. Dallas, Tex.

Mar. 10–11, 1950. Area A—Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont. Hartford, Conn.

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The Children's Decade

Ellen Key, famous Swedish author, in the closing years of the nineteenth century, expressed the hope that the twentieth century would be the Century of the Child. In spite of great gains that have been made for children, no one can be so bold as to claim that the first half of the twentieth century has lived up to this prediction.

Now, at the halfway mark, citizens who are sensitive to and impatient with our unfinished business of children are challenging all of us to rededicate ourselves to the achievement for all children of the chance to grow in happiness and social responsibility which should be the birthright of every child.

One challenge comes from George J. Hecht, chairman of the American Parents' Committee.

"Because in the next 10 years the United States will have a record child population, we are now entering upon what can well be termed the Children's Decade," Mr. Hecht writes.

"If the Children's Decade is to exemplify the high standards in education, health, and welfare that we want for our children, you and I and the groups and communities with which we are identified must set to work at once.

"Let us resolve at the beginning of the New Year that this next decade shall bring our children good homes, good schools, good health. It is a big undertaking seen on a national scale. But in terms of your community, your State, it is possible if you will work for it. If you are aware and determined, you and I and the groups to which we belong can make these next 10 years known with pride as the Children's Decade."

Katharine F. Lenroot

Chief, Children's Bureau

Cerebral-Palsied Child Needs Teamwork

Ours is a complex society, with greater tendency toward specialization. While doing our own particular job, some of us may lose sight of the contributions of other individuals and groups working toward the same ends. Sometimes it takes a complex problem to bring us closer together.

Cerebral palsy is this kind of problem. Within the past decade, as Dr. Wishik tells us in this issue of *The Child*, efforts to develop the coordinated care needed by cerebral-palsied children have helped to bring groups from varied fields and endeavors into concerted action. Public departments and voluntary agencies have established cerebral-palsy programs. Lay groups and professional organizations have pooled their efforts. Within the professions, educators, physicians, and allied health workers have worked shoulder to shoulder on cerebral-palsy services in closer fashion than in almost any other phase of their cooperative activities.

Our objectives for the cerebral-palsied can be attained only through continuation of such concerted efforts, especially between public health and education. In research, as these efforts continue, medical and educational techniques will be developed side by side. In services, professional workers will complement one another. As part of the training of professional cerebral-palsy workers, they will learn together how to become members of a team.

Coordination of the work of health and educational personnel to help the cerebral-palsied necessarily depends on a solid framework of the broad services for children in both the health and the education fields. Primarily, that means strong local health departments, more specially trained personnel, comprehensive services for crippled children, and all-inclusive educational programs for exceptional children. With all of us working together for these common ends the immediate future holds promise for progress in our acquiring greater knowledge concerning cerebral palsy and in giving better service to the cerebral-palsied.

Edwin F. Daily

Director, Division of Health Services
Children's Bureau

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Managing Editor Sarah L. Doran
Art Editor Philip Bonn

FEDERAL SECURITY AGENCY
Oscar R. Ewing, Administrator

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Arthur J. Altmeyer, Commissioner

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Katharine F. Lenroot, Chief

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the CHILD

FOSTER HOMES IN MEDICAL-CARE PROGRAMS FOR CHILDREN

U. S. SUPERINTENDENT OF DOCUMENTS
MAR 20 1950

ELIZABETH E. BISSELL, General Secretary, the Children's Mission to Children, Boston

FOSTER care for children has many reasons for being, many uses. One specialty is the placement of children away from their own homes in medical foster care. The Children's Mission to Children, a century-old privately supported agency in Boston, provides this care for children with medical problems. It is the only agency giving this service in this locality, because of a joint decision made by the children's agencies of Boston.

The work of the Children's Mission to Children has gone through many changes during the agency's recently completed hundred years, but it has always held to the original aim of "helping any child in need of a friend." (In its most recent change, early in 1949, the agency affiliated with the Children's Medical Center and moved its office so as to be near the center.) The agency has been placing children in foster care for five decades and placing them in medical foster care for three of these decades.

The agency now serves hospitals, clinics, private practitioners, and social agencies by providing foster-home care for convalescent children who, for medical reasons, should not go home for a while. It also places in foster care children who have been ill in their own homes, but for full recovery need convalescent care elsewhere.

In these carefully chosen foster homes the children accepted by the agency for care make the transition back to their ordinary mode of life.

Naturally, many problems arise when an active child's life is suddenly changed to one in which he must curb his energy, giving up almost every activity he has. The problems may be physical difficulties, emotional disturbances, or the break in his education. Many of the children are recovering from rheumatic fever or chorea and so need long-time care and the service of several types of specialists if they are to make all-round progress as well as physical recovery. Physicians, nurses, social workers, foster parents, occupational therapists, school teachers, and others work together to bring about a new, unhindered start for children who have had serious set-backs.

Homes of two kinds

The Children's Mission to Children offers medical foster care to boys and girls in two types of homes:

Care in the homes called by the agency "medical homes" or "group bed homes." These homes serve children needing bed care, such as children with bronchiectasis, arthritis, nephritis, hemophilia, spinal fusion, asthma, cerebral palsy, or rheumatic fever.

From 4 to 14 children are cared for in a home. The agency would prefer to limit the number to 6 if that could be worked out. As it is, the foster mothers who care for a larger number than that are unusually competent women, able to maintain individual relations with each child in their constantly changing groups, and the conditions in their homes are unusually advantageous. The agency guarantees regular payment for a specified number of children in each home, regardless of whether all the beds are filled. It usually has about five such homes at one time.

Care in Eliot House, a convalescent home owned by the agency, is for about 12 boys at a time. It was opened in 1946 because of a shortage of family foster homes for medical care.

A child in one of these homes is considered ready to return to his own home or to be transferred to a "nonmedical home," which will be described here, only when he is able to be up and about for 8 hours in the course of a day.

A study made of the agency's program in 1947 showed the median length of care in medical homes to be from 3 to 4 months.

Care in the "nonmedical" or "up" homes for ambulatory children who have medical problems. The purpose of these homes is to give a natural family setting to children who can be out of bed but whose activities must be restricted, who must have rest periods, good food, and medical supervision.

Children whom we are most apt to place with an individual foster family are in one of two groups. They are children who, to safeguard their health, need long-time care away from home, or who need summer-vacation care in suburban or country homes to get them away from city slums or other unfavorable city conditions. The latter may be children who are past the convalescent stage of rheumatic fever but are not yet well enough to go to a regular summer camp.

About 20 nonmedical homes may be in use at one time. The median length of care in these "up" homes was, at the time of the study, from 2 to 3 months.

The boys and girls under care

The number of children under the care of the agency at any one time is approximately 80. Some of them are being served in some way in their own homes. The number is smallest in the autumn before rheumatic fever in the acute stage is prevalent. About 50 percent of the children cared for have had rheumatic fever. During the summer vacation from 20 to 30 children are added to the usual number—children who need help in keeping their activities limited and in following the preventive measures required of them.

Most of the referrals are made by

hospitals. When a request for service is received, the child's mother and father usually visit the agency's office to discuss the matter. If they decide they want the agency to give service, and placement is possible, the plan is talked over with the child before any arrangements are made. Parents and child take part in whatever planning is done.

The boys and girls accepted for admission are, in general, from 2 to 21 in age, without infectious disease, and not acutely or hopelessly ill, although the prognosis may be poor or questionable. There are no residence restrictions, and no restrictions based on race, religion, or finances. The family is expected to pay all or part of the child's expenses, if possible. But whether the family can pay is not considered in deciding about acceptance. "Can the service help this child? And have we a suitable vacancy for him?" In general, the answers to these questions decide the acceptance of an application.

It is hard for a child to stay quiet when he is getting well. An occupational therapist can help such children to keep busy and happy without their becoming too fatigued or excited.

The foster mother is the pivot

Any placement agency undertaking to care for children with problems arising from illness has, as the core of its responsibility, the job of restoring boys and girls to health as quickly as possible. It tries to do this by facilitating any medical treatment being carried on by the hospital, clinic, or private physician referring a child for foster-home care. The direct responsibility for the child's daily care rests with the foster mother. Therefore it is the agency's duty to select women in whom it can place full confidence. In this program foster mothers are chosen for the same personal qualities that are required for any foster care in family homes—the qualities that make a good mother. They are warm-hearted, yet calm under stress; they understand children. In addition, these foster mothers are chosen for their appreciation of how children react to illness and how different diseases affect children. (Many of our foster mothers are graduate nurses.) A foster mother must help a child who has been ill, and who is away from his family, to be contented with his surroundings and to follow the regimen planned for him by his doctor.

The agency should appreciate fully the significance and worth of the job a foster mother assumes and should compensate her adequately. Having financial security is important to a woman who undertakes in her home the care of a number of children who are confined to bed or of one child who is under special medical treatment.

The Children's Mission to Children pays its foster mothers for the care they give in group bed homes from $14 to $21 a week for each child. Providing equipment is the responsibility of the foster mother. But expenses she incurs for the children, such as medicines, haircuts, clothing, transportation, allowances, are chargeable to the agency.

Foster mothers make financial agreements with the agency's administrator—its general secretary—and the supervisor of foster care. The agreements usually run for a year, at the end of which time an evaluation of the foster care is made and adjustments may take place to improve the service. However, the agreements are not necessarily binding for a full year and may be changed at any time if it is desirable.

A child's mother and father need to feel confidence in the person who is to care for their ailing child. Some get this confidence from their belief that the agency will choose foster parents wisely, and they accept the choice without question. Others wish to see and judge the foster home for themselves during the planning period, before the child is placed. An opportunity for a visit is, of course, arranged. If they wish, the parents go with their child and the case worker on the day the boy or girl enters a foster home. The agency encourages the fathers and mothers to go if they seem hesitant about it.

Parents are urged to visit their children once a week. Visiting hours in group bed homes are arranged to coincide, at regular intervals, with the medical director's call, so that parents may talk with him about their son or daughter.

The medical director

The medical director of the agency is a specialist in rheumatic fever. He serves the agency part time in addition to carrying on his private practice and his staff work at two hospitals, the Children's Hospital and the House of the Good Samaritan. The latter gives sanitorial care to children who have rheumatic fever. Because many of the children come to the foster homes from these hospitals they have the advantage of continuity of medical care during the acute and convalescent stages of their illness.

The medical director makes regular visits to group bed foster homes and in addition is on call to these homes at any time. He may be consulted on any case in the care of the agency. On three afternoons a week children may be taken to his office for examinations. He is consulted on the admission and treatment of every child with rheumatic fever, cardiac involvement, arthritis, or chorea. Two physicians who are his assistants make additional visits to the homes.

Children who have had illnesses other than rheumatic fever are supervised medically by the hospital, clinic, private practitioner, or medical agency that referred them. They are taken regularly to hospital, clinic, or doctor's office, according to the source of their supervision, for examination or treatment.

In the nonmedical foster homes, foster parents report any illnesses, however slight, to the agency. If a child who is being supervised medically by a clinic or hospital shows signs of illness, the supervising clinic or hospital is notified at once. A foster mother may call her own physician in an emergency, with the approval of the medical director, but in practice it is seldom necessary. Case workers, foster mothers, or case aides take children to clinics in the agency's car or in an ambulance for routine check-up examinations or for special treatment.

Others who visit the homes

The agency's laboratory technician visits the group bed homes regularly and also when called there for specific reasons.

Occupational therapy is given when a doctor prescribes it. An occupational therapist, who is a full-time staff member, visits the group bed homes twice a week. Her type of work is treatment through activity—either mental or physical activity. The doctor indicates the diagnosis, the results that he wants to achieve, and the precautions to be observed. With these instructions and information about the child and his family the therapist selects activities best suited to help bring about the physical and psychological results the doctor is trying to bring about.

This technician's report to the doctor will help him to judge the little patient's progress.

Treatment, which may be given to individuals or in groups, includes such arts and crafts as leatherwork, puppetry, sewing, woodwork, finger painting, and such recreation as singing and dramatics. The activities suitable for our rheumatic-fever patients (they constitute about 90 percent of the children in our two group bed homes) are those that are "freeing" and creative.

The agency's social case workers visit the homes whenever it is necessary—they have no regular schedules. Their coming depends on the needs of the individual children and on when the foster mothers want to talk over special matters. The agency places much emphasis on its case-work services. These services are discussed at length further on. (See *Social Case-work Service*, on next page.)

The Board of Education supplies teachers for the children, just as it does for other home-bound boys and girls. Various churches send volunteers to give religious instruction to the young people of their own denominations while they are in the homes.

The Visiting Nurse Association of Boston arranges for its public-health nurses to go to the foster homes whenever their services are needed.

To everyone, having satisfactory living surroundings means a great deal. To an ill child who is wholly or partially isolated from most of his usual contacts, his background is particularly important.

Living conditions

Houses selected for the care of small groups of convalescent children need to be spacious enough so that the children can use more than the space immediately around their beds. One advantage of foster care in a home is that the patients may take part in family life. A child convalescing from an acute attack of rheumatic fever, who has advanced from complete bed care to being allowed to get out of bed to go to the bathroom, can at least stop by the kitchen on his way back to bed to see what's cooking or to suggest something he would like to have for dinner.

What factors does a home finder on the agency's staff consider when she is studying a prospective home for group foster care? She considers the location of the house, its exposure to the sun, its ventilation, its heating facilities, and the location of its bathrooms. She considers whether its stairs are easy to use, whether it has rooms for isolating patients and space for teaching and for occupational therapy; she notes the nearness of children's rooms to the center of household activities, the yard space suitable for outdoor recreation, and the nearness of the house or the convenience of transportation to the city's medical centers.

The standards outlined for group bed homes cover practical aspects. The agency's requirements specify the equipment necessary, such as beds, bedside facilities, linen, and thermometers. The requirements cover the diet, the preparation and serving of food, the changing of bed linen, house-cleaning methods, the care of patients, and the clothing to be supplied. Other subjects covered are: Safeguarding the children against infection; visiting days and hours; competent assistants for the faster mother; and her reports to the agency.

The foster mothers in a medical-care program find it helpful to meet to discuss their common experiences and problems and to hear speakers on subjects close to their work. Such meetings have been held quarterly, and the foster mothers have recently organized a program committee to plan more meetings of this sort.

The mothers discuss such subjects as food, children's books, and emotional difficulties of children. At one meeting they exchanged food recipes, and talked about using parents' recipes for dishes that they, the foster parents, were unfamiliar with. Some of these were foods liked by families that still follow the cooking habits of their old-country forebears.

At the meeting on books, the foster parents discussed the selection of titles suitable for different age groups and how to encourage good reading habits.

A psychiatrist led a discussion on the emotional difficulties of sick children who are separated from their families. The foster mothers brought out with much interest various ways to handle effectively the beginning of a child's stay in a foster home, their experiences in giving the child the affectionate care he needs all the time he is in the home, and how to work out relations with the parents.

Appreciation of work well done comes to the foster mothers in various ways. Perhaps the most rewarding of all is the comment of a physician as he examines a child in the foster home or clinic. At this time he notes the progress and speaks of it. On these occasions the foster mother, physician, nurse, and case worker can rejoice together over the child's gain and can confer on further steps. Helping a child to return to health has other satisfactions. Foster-home "alumni" groups are growing in number and in enthusiasm. The unofficial follow-up that happens spontaneously when former patients visit, write, or telephone foster mothers is satisfying to the mothers and usually to the former patients also.

Social case-work service

The function of the agency, as we have said, is to provide care in foster homes to children with medical problems and to provide them and their families with social case-work service adapted to a medical-care setting. These services include: "Intake" activities, that is, interviewing applicants for the agency's service and studying the situation to ascertain the suitability of the service for the child; finding desirable foster homes; and counseling with parents and with foster parents. The case worker coordinates the services in the foster home with the services of the medical director, of hospitals, of clinics, and of private physicians whose patients are in the home, and with the services of the other professional workers who may serve the children.

Because children are referred to the agency on the basis of medical considerations, the case worker's first concern is the medical data available from the hospital or other agency or person referring the child. When this, with the summary of the social study made, is in hand, the first interview with the parents takes place and planning begins. The case worker makes a visit to the child's home. If the boy or girl is away in a hospital or an institution, the worker visits him there to establish the link between them.

She explains the service to the child's family—what the foster homes are and what the foster mothers do, and what medical supervision is provided. She tells the family about activities in the foster home. As the child's parents learn to know the case worker, they gradually reveal to her what the most acute problems are. That helps the worker to decide what the focus of her treatment may be.

The benefits these children and parents may derive from case-work service grow chiefly out of the relations between the worker, the parents, and the child in their united efforts to restore the child to health. Many others share in these efforts. The case worker makes available to parents and child her ability to help them with their emotional problems—or any problems that are related to the child's illness. If they can learn to make use of the worker's knowledge of why people—children or adults—act as they do and of her skill in helping people solve their problems themselves, they can sometimes find

(*Continued on page 124*)

He's going home! His foster mother of 6 months and her family of boys are glad he is well.

HOW MANY BABIES?

DOROTHY D. TUTHILL, Ph. D.

THE LARGEST NUMBER of births in the entire history of the United States was chalked up in 1947. Although the number was high in 1948, and the estimates show that it will be high in 1949, 1947 is still the leader. With so many births occurring annually, it takes time to collate all the necessary information about the people who have babies, and it was not until the middle of 1949 that the National Office of Vital Statistics released detailed data on the record-breaking number of births occurring in 1947.

Record number of babies born

The number of births registered during 1947 was 3,699,940. Actually, the number of births during the year was greater, because the births of an unfortunate group of babies, estimated at about 4½ percent of the total, did not have birth certificates filed for them. The number of babies that do not have certificates is thought to be decreasing in proportion annually because now no reputable doctor will assist at a delivery, and no hospital of standing will accept a maternity patient, without making provisions for the baby to have the advantage of one of the most personal and most important of all legal documents, a filed certificate of birth. It is probable that slightly more than 175,000 births were not registered; therefore the estimated total of infants born during the year is 3,876,000.

About 400,000 more births were registered in 1947 than in 1946, and the figure for the 2 years combined is almost 7,000,000.

A birth rate is a handy tool for making comparisons in the number of births from year to year when we wish to consider the size of the population at the same time.

The graph on this page, published March 30, 1949, by the National Office of Vital Statistics, shows crude birth rates calculated for each year since the individual States started sending facts about births to the Federal Government. (Special Reports, vol. 31, No. 2.)

One glance at the graph and we can understand why the population experts are watching the Government's annual reports on births as carefully and as anxiously as a stockbroker studies the ticker tape.

A fairly consistent decrease in the birth rate is observable from 1915 to 1933, with the exception of the sporadic peak following World War I. The low point in 1933 is unquestionably related to the economic depression. Because of the poor employment picture during the thirties, marriages and children were postponed, and this caused a drop in the rate. The birth rate was so low during the depression years that if it had continued at that level for any extended period, the population of the United States would have decreased, in spite of the declining death rate.

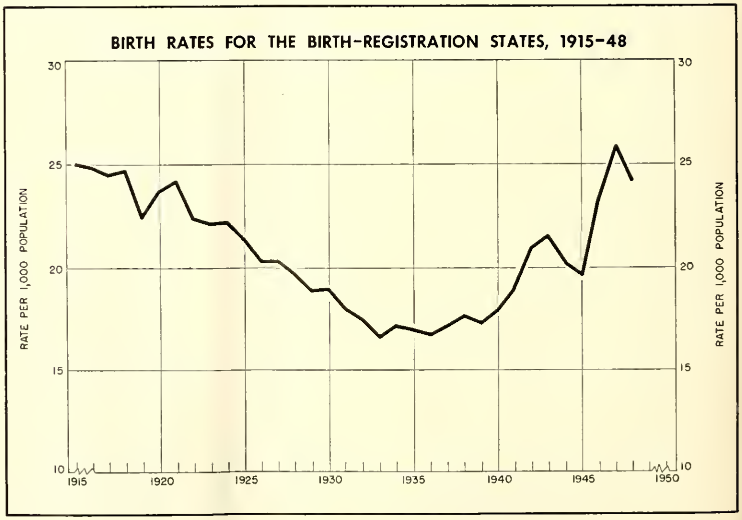
Births rose in early war years

The high economic level during the years just before the last war, together with Selective Service legislation and the anticipation of a conflict involving our country, accelerated the marriage rate. And within a year the birth rate began to rise fairly sharply. By 1943 the birth rate had climbed to a level comparable to that in 1925.

The next change in the trend was a decline, extending over a 2-year period coinciding with the shifting of husbands and prospective husbands from the general population into the Armed Forces. In midyear 1945, a month after VE-day, it is estimated that about 7½ million members of the population were out of the country.

However, demobilization began to occur fairly rapidly after VJ-day, and many returning servicemen married. The highest marriage rate ever recorded in the United States, a rate of approximately 16 marriages per 1,000 of the population, was tallied in 1946. During the year 32 people out of every 1,000 in the population said, "I do."

The high marriage rate, relatively good wages, and our national demand for consumer goods that we had voluntarily denied ourselves during the


BIRTH RATES FOR THE BIRTH-REGISTRATION STATES, 1915–48

war years all combined to make conditions auspicious for a new increase in the birth rate. The graph shows the steep rise for 1946. Some experts thought that the rate would surely decline in 1947, but instead it rose still higher.

How old are the women who are having such a relative abundance of babies? In 1947 women between 20 and 24 years of age had more babies than women in other age groups. And, women between 25 and 29 came next. These two groups, including women between 20 and 29, were the mothers of more than 60 percent of all the babies born in 1947.

The number of women in the different childbearing years is not the same, and so a rate is used to express the proportion of women in any age group having babies. This rate is called the "birth rate by age of mother."

How to calculate a birth rate

It is figured by dividing the number of live births to women in a specific age group by the number of women in that age group. Sometimes this rate is criticized because not all the women in the age group are married, and because a sizable number of those who were married are divorced each year. Of course some divorcees remarry within a short time and some do not. Then there are other women in the age group who are married, but either they or their husbands are sterile and consequently cannot add to the number of births.

The next graph, published October 8, 1948, by the National Office of Vital Statistics, shows birth rates, by age of mother, from 1920 to 1947. (Special Reports, vol. 33, No. 1.)

The graph shows clearly what was mentioned earlier, that births to women between 20 and 29 years of age are consistently higher than those for any of the other age groups; this finding is not unusual.

The findings that the graph points up are that from 1920 to 1947 the greatest variation in the rate was within these ages. This is the group that has apparently reacted most strongly to changes in the economic pattern and to the displacement of men by induction into the armed services.

A second fact that caused fresh speculation among population experts was that birth rates were higher in 1947 than in 1940 for *all* age groups of women. In other words, a larger proportion of women 35 years of age or over had babies in 1947 than in the years just preceding the war. The impetus to start, or to add to, an already established family has definitely not been confined to the younger women. One may also speculate about the fact that birth rates for women less than 30 years old were all higher in 1947 than they were in the period following World War I.

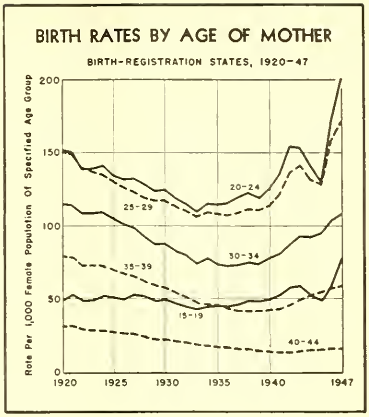
One way to approach the question of family size is to survey the birth data by order of birth. How many of the new babies in 1947 were first babies, and how many arrived to discover that they had an older brother or sister? There is no question that the record of almost 2⅓ million marriages in 1946 contributed to a remarkably high rate of first babies in 1947. In fact, the number of first babies to every 1,000 white women between the ages of 15 and 44 years in 1947 was approximately 22 percent higher than the corresponding rate in 1946. There were increases also in second and third births, but these increases amounted to one-half or less the increase for first births. The proportion of fourth and higher-order births changed only slightly.

In round numbers, for 1947 alone, 1½ million families had their first child; a second child was added to nearly a million additional families; and another half-million families had their third child.

Families postponed by war

After sifting through these and additional facts, P. K. Whelpton, of a research organization at Miami University, Oxford, Ohio, finds that the record-breaking number of first births in recent years is largely the result of starting families that were postponed by the war, and of the decisions by newly married couples, because of prosperous times, to have a first baby within a year or two. He believes that the boom in second and third babies is related to similar decisions, but not necessarily to a lasting increase in average family size.

When wages are good and the chances of unemployment appear slight, the financial responsibilities associated with having a baby, such as the hospital and doctor bills and a layette and other equipment, plus a little every month toward a college fund, do not appear unattainable. Furthermore, the recent war years brought an insistent demand for a large domestic labor force, and this led to an extension of nursery-school facilities so that more mothers of young children could work. These facilities are in part still available for women who are convinced that they can successfully combine child rearing and working.


BIRTH RATES BY AGE OF MOTHER

BIRTH-REGISTRATION STATES, 1920–47

With the popularization of new material on the psychological importance of family structure to the growing personality of the child, the fact has taken root that youngsters who are not many years apart can enjoy each other more and contribute more to their mutual socialization. When times are hard, parents may not contemplate having a second or a third child until the family finances seem more secure. As a result, children are farther spaced and many have less in common. When family income appears fairly stable and adequate, having two or three youngsters not more than a year or two apart is less hazardous an undertaking.

There is no question that if the fertility pattern for 1947 were to continue over a period of a decade or more, there would be a growing trend toward larger families than we see now. With the fresh and continuing data provided each year by the National Office of Vital Statistics, we can periodically speculate on the far-reaching implications of such questions as changes in family size and in the birth rate ups and downs.

AMENDED FAIR LABOR STANDARDS ACT IMPROVES PROTECTION OF CHILD WORKERS

WM. R. McCOMB

Administrator, Wage and Hour and Public Contracts Divisions, U. S. Department of Labor

JANUARY 25, 1950, marked a major advance in Federal protection of boys and girls employed in interstate industry. For, on that day, amendments to the child-labor provisions of the Fair Labor Standards Act of 1938 became effective, amendments that will do much to eliminate the evils of child labor.

The amendments have broadened the act in two ways: (1) It now protects children in some interstate industries that were not covered by the original act. (2) It now gives children in agriculture its full protection during school hours if the crop is for interstate commerce.

The protection of the act is now extended to a great many more children and young people than were previously reached. In industries other than agriculture, an estimated 75,000 more young workers will be protected during the school year and 150,000 during the summer. And uncounted thousands of children will have an opportunity to go to school instead of working in the fields while school is in session.

Originally the child-labor provisions applied only to children employed in or about an establishment producing goods for shipment—or delivery for shipment—in interstate commerce, if the goods were removed from the establishment within 30 days of the employment of the under-age children. This meant that most of the children working in the transportation, communications, public-utilities, and contract construction industries were outside the child-labor protection of the act, as well as many working in trade. For many establishments in these industries did not produce goods for interstate shipment. Now the child-labor provisions have been extended to prohibit directly the employment of "oppressive child labor" (as defined in the act) in interstate commerce or in the production of goods for interstate commerce. As a result, minors working on boats, or for trucking concerns or railroads, or as telegraph messengers, and in some other lines of work will also be protected.

Also, for the first time, children in agricultural areas have the same protection from employment that would interfere with their opportunity for schooling as do city children. The child-labor provisions of the act, although they applied to some agricultural employment, did not apply to such work except at the times when children are required by State law to attend school. Although this might seem to protect children from agricultural employment that interferes with their schooling, it did not work out that way in all the States.

These provisions now apply in all States to all children under 16 years of age employed on farms producing crops for interstate commerce (other than their parents' farms) except when school is not in session.

The only other exemptions from the child-labor provisions of the amended act, outside of the exemption in case of employment by the child's parent, are for children employed as actors and performers in motion pictures, theatrical productions, and radio and television productions; and for employees engaged in delivery of newspapers to the consumer. Exemption of employment by a child's parent applies only to occupations *other than* manufacturing, mining, or hazardous occupations.

No change has been made in the minimum-age standards set by the act. The minimum age for employment in occupations covered by the act is still 16 for children working at most jobs; 18 for those working in particularly haz-

(Continued on page 127)

CHILDREN BENEFIT FROM OLD-AGE AND SURVIVORS INSURANCE

NAOMI RICHES, *Division of Program Analysis, Bureau of Old-Age and Survivors Insurance, Social Security Administration, Baltimore*

MORE than six hundred thousand children are now receiving monthly benefit payments from old-age and survivors insurance under the Federal Social Security program.

Many of us may be accustomed to thinking of the old-age and survivors insurance program mainly as providing some income for old people who are no longer earning wages. As a matter of fact, this was true of the program as originally defined in 1935 when the Social Security Act was passed. Benefits for the worker's family after he retires and after his death were added by amendments in 1939.

When the breadwinner of a family dies, the children, even as other dependents, might be left in want but for the income provided by some kind of insurance; the survivors insurance provisions of the Social Security Act help protect children against such want. And though of course there are not a very great number of children under 18 whose fathers are past 65, those children also often need the protection given them by the children's benefits included in their fathers' old-age insurance.

Present act provides for children

Thus Social Security insurance, which began but a few years ago as a system to provide a small retirement income for workers as individuals only, today includes two features of direct importance to children—the additional benefits for children of retired workers and, much more important even, the benefits for the children of workers who die earlier in life.

Children's benefits from old-age and survivors insurance are one of the three ways in which the Social Security program helps families protect their own children. These three ways are through insurance, through assistance, and through community services. The insurance is called old-age and survivors insurance; through it a worker earns rights to insurance benefits for his family (in addition to his own benefits) when he retires after reaching the age of 65, and insurance benefits for his family when he dies. The assistance plan is called aid to dependent children; through it, payments are made direct to families for children in need. The community services are the health services and social services for children and the services for crippled children, which are provided with the help of Social Security grants. Under the Social Security Act, the insurance provisions are handled entirely as a Federal Government program—it is the only program under our Social Security system that is actually operated by the Federal Government. Aid to dependent children and the various services for children (as well as the rest of the programs under Social Security) are provided by the States and localities with the help of Federal grants-in-aid.

Of the three ways in which the Social Security Act helps safeguard children, children's benefits from insurance are perhaps the least well known. Hence, some explanation of old-age and survivors insurance as it concerns children may be of interest to readers of *The Child*.

Insurance benefit payments for children are made on the basis of the insurance earned by their parent (usually, their father, though a mother may be an insured wage earner). Consequently, the first requirement in order that a child may receive benefit payments is that he be the child (natural or adopted) of a worker insured under the Social Security Act.

Benefits are payable to a child of an insured worker who has reached the age of 65 and has retired, and to a child of an insured worker who has died. In either case the benefits are paid for the child each month until he reaches 18 years of age, except that no benefits are payable to a child who has married, and no benefit can be paid for any month in which the child is employed in industry or commerce and receives wages of as much as $15. And if the child's benefit is based on his parent's retirement benefit, both the parent's monthly benefit payment and the child's monthly payment are held back for any month in

More than six hundred thousand children in the United States are now receiving monthly benefit payments from old-age and survivors insurance under the Social Security program.

which the parent receives $15 or more as compensation for employment in industry or commerce.

To go a bit more into detail (but still generalizing a great deal), let's start with the wage earner whose insurance provides for his child's benefits.

Insurance under Social Security is much the same as all "retirement insurance." It is insurance purchased by the payment of premiums over a period of time. The big difference in Social Security insurance is that the premiums are paid in the form of a "withholding tax." Beginning the first of 1937 a Social Security tax has been paid on the wages of jobs that the Social Security Act placed "under Social Security." That Social Security tax is, in effect, the payment of premiums on an insurance policy, so that workers in jobs under Social Security become "insured." The act goes into some detail concerning the kinds of jobs that are covered and those that are not covered, but we can describe them in broad terms. Jobs under Social Security comprise practically all jobs for wages (that is, when the worker is not self-employed) in industry or commerce—work in offices, stores, factories, construction, and so on. Jobs that are not under Social Security comprise, still speaking broadly, jobs in agriculture, jobs in domestic service, government jobs, and the jobs of those who are self-employed, who don't work for somebody else, like doctors, lawyers, owner-operators of small grocery stores, and so on.

So a worker in a job under Social Security is in effect automatically paying premiums on insurance—for himself and his family. But for a worker to be entitled to retirement benefits, or for his family to be entitled to survivors benefits if he should die, he must have worked in jobs under Social Security for a certain minimum length of time. The amount of a worker's benefits, and of his family's benefits, is determined by the total amount of wages he has received from all his employment in jobs under Social Security.

The minimum period of covered employment required for a worker who reaches the age of 65 is, roughly, half the time from January 1, 1937 (when Social Security coverage began), to the time he reaches age 65. The employment doesn't have to be continuous, and all employment in covered jobs is counted. A worker (at any age) who has completed a total of 10 years of covered employment is insured for life, regardless of future employment—but of course the size of his benefits at retirement, or of his family's benefits if he dies, will be based on the amount of his wages from all his covered employment.

The minimum period of covered employment required in the case of a worker who dies is similar, that is, half the time from the beginning of 1937 to the time he dies. Or he could be permanently insured with 10 years of covered employment. Or he is insured at death if during 3 years preceding his death he was in covered employment for approximately half the time.

It may be noted that although the benefits for survivors were not added until 1939, a worker's employment is figured from the first of 1937 for survivors insurance just as for old-age insurance, since that is when the workers came under Social Security.

The 10-year provision for a permanently insured status is not especially significant at present, inasmuch as Social Security has been in effect only some 12 years. But when the insurance program has been in force a few years longer this 10-year provision will have increasing importance for many workers, since it will probably become a less difficult condition to meet than the provision of half the time since the act became effective.

When an insured wage earner reaches the age of 65, and is no longer employed in a job *under Social Security* (to be a little more exact, if he no longer works for wages of more than $14.99 a month in employment that is under Social Security, though he could work for compensation of any amount in a job that is *not* under Social Security) he is entitled to a monthly benefit payment. That monthly payment to the retired wage earner is spoken of as a "primary insurance benefit." Its size depends on the amount of wages and the length of employment in jobs under Social Security. The law says that in any event it shall not be less than $10 a month. At present the most that a retired worker's benefit could be is a little less than $50.

In the case of a worker who dies, a "primary insurance benefit" is computed in the same way as for a worker who retires, and the amount of this primary insurance benefit of a deceased worker determines the amount of the survivors benefits payable to his family, just as the additional benefits for the family of a retired worker are based on the amount of the worker's own primary insurance benefit.

A child's insurance benefit is based on the primary insurance benefit of his insured parent, whether the parent has retired or has died. The amount of a child's monthly benefit ordinarily is one-half the amount of his parent's primary benefit. Each of a worker's unmarried children under 18 years of age is entitled to a child's benefit. A widow of an insured worker who has a child or children of the worker in her care is entitled to a "widow's current benefit" amounting to three-fourths the amount of the worker's primary benefit. The widow's current benefit is payable regardless of her own age. (The wife of a retired worker is entitled to a wife's benefit amounting to one-half the worker's primary benefit, when she herself reaches the age of 65; the widow of an insured worker is entitled to a widow's benefit amounting to three-fourths of the worker's primary benefit when she reaches 65, regardless of whether she has children in her care.)

As we have noted, a child's benefit is paid each month until the child reaches 18 or marries, except that no benefit can be paid for any month in which the child is employed in industry or commerce for wages of as much as $15. A monthly check is paid to a widowed mother as long as she has a child beneficiary in her care, provided she has not remarried and is not earning wages of $15 or more a month in employment covered by Social Security. If her benefits are suspended by reason of such employment, her children nevertheless continue to receive their monthly benefits. Likewise, if she remarries, her own benefit payments are stopped, but the children continue to receive theirs.

Maximum set by law

There are limitations on the benefits that can be paid one family, that is, that can be based on one worker's wage record. The law says the survivors benefits for a family must be at least $10. It limits the maximum amount in three ways. It states that the total benefits payable to one family cannot exceed whichever is *smallest* of three amounts, either $85, or twice the amount of the worker's primary benefit, or four-fifths of the average monthly wage on which his primary benefit was based. If applying any of these "maximums" would reduce the total of the family's benefits to less than $20, the total amount is kept at $20.

As of June 1949, the average payment made to a child was about $13 a month and the average payment made to a widowed mother was about $21 a month. In that month alone, some 8 million dollars were paid to about 615,000 children and some 3 million dollars to the widowed mothers. From January 1940, when family benefits were first included in the insurance program, to June 1949 more than 447 million dollars were paid to survivor children and nearly 217 million dollars to their widowed mothers. During the same time more than 18 million dollars were paid to children of retired workers. Since the program began, more than 900,000 children have been awarded monthly benefits.

These benefit payments, like the rest of the insurance benefits under Social Security, came from the trust fund into which wage earners in covered employment, and the employers of those wage earners, contribute equally through the Social Security tax.

Survivors insurance under Social Security, like other forms of insurance, is a method of spreading the risk. The death rates for the ages at which workers would be expected to have young children are not so high, and by spreading the economic risk of early death among all workers, each worker can have protection for his own family at relatively low cost.

Parent provides for child's support

Insurance payments to the family are made with no means test, no case-work investigation, and are subject only to verification of the age of the children and the relationship of the dependents to the deceased worker. A child can feel that provision has been made by his parent for continuing some financial support even after the parent's death.

Not all of the children's benefits are paid on wage records of fathers. A widowed mother may be the insured breadwinner who dies and on whose wage record benefits are paid to her children.

For total orphans whose parents were both insured workers, monthly benefits are paid on either the father's or the mother's wage record, whichever gives the higher benefit. In the case of children nearing the age of 18 the checks are usually made out direct to them. For younger children the payment is customarily made in behalf of the child to a person with whom the child is living.

Orphans are more numerous than many people suppose. The latest figures now available are from the 1940 Census. They show that nearly a tenth of the more than 40 million children under 18 have lost one or both parents. Of these, more than 2 million have lost their fathers and more than a million have lost their mothers. Nearly 300,000 have lost both parents. The 1950 Census will undoubtedly show an increase in the actual number of orphans because of the increase in the whole population. The proportion of orphans to the total number of children will probably be about the same. War casualties fortunately were not so large as to affect the situation in this country as they did in European countries. The 1940 Census gives some interesting data by age for these orphans. Of all children aged 15 to 17, nearly 18 percent have lost one or both parents. About 3 percent of all children under 5 have lost one or both parents. Students of population problems have observed that complete orphanhood is much more frequent than would be expected from the separately computed chances of losing father and of losing mother. There are more than 10 times the number of total orphans that might be expected on the assumption that the loss of one parent has no effect on the probability of also losing the other.

Congress made provision in the Social Security Act as amended in 1939 for continuing study and for "recommendations as to the most effective methods of providing economic security through social insurance." Accordingly, the Social Security Administration has recommended that social insurance protection be extended to all those gainfully employed, and that the amount of the monthly insurance benefit payments under the act be increased.

For a baby and his widowed mother, survivors insurance under the Social Security Act will provide monthly insurance benefits that will continue for both until the child is 18 years old.

FOSTER HOMES

(Continued from page 117)

their way out of the situations that have contributed to the necessity for foster care.

Case-work service, like other professional services that help people understand their difficulties, sometimes seems clearest when its benefits to a specific person are told, along with the way the benefits are brought about. We might look, therefore, at service given to one child in order to see what the agency's case workers try to do for children. Our story is about a child who has asthma and uses it to get her way about things, and in doing so has a serious illness and stays younger than her actual years and behind her capacity for development.

A case worker and one little girl

A children's hospital asked the agency to place one of its recently discharged patients, 6-year-old Maria Q. She had come to the hospital acutely ill as a result of asthma, which she had been having for 3 years. She was greatly improved at the time of her discharge from the hospital. She stayed briefly in an institution for convalescents before she went back to her family and she was entirely free from symptoms as long as she was away from home.

Now at home, she was having attacks again. At the hospital and at the institution she had had a good, healthy appetite. At home she was eating, between meals, all sorts of food that was not good for her. Someone had to dress and undress her. Her entire family—parents, grandmother, and the three older children—gave in to her; if they did not, she would have an attack of asthma. The latest development was her refusal to go to school. The doctor requested foster care for her because he believed the child's life would be endangered if she continued to have severe attacks; she was likely to continue to have them unless her home situation was changed.

What was the situation that was leading to Maria's physical illness? When the agency's case worker first talked with the child's mother about the possibility of Maria's going to a foster home until health habits could be established to prevent asthmatic attacks, Mrs. Q. asked axiously, "When my little girl was so well at the institution, why does she have asthma as soon as she comes home?" The case worker helped her find the answer to that question through many talks with the parents and with Maria herself during various associations; by close observation of the relations between the different members of the family; and through the various case-work processes by which the worker helps persons to learn to see their problems more clearly and to face the need of solving them.

Briefly, here is the home situation that faced Maria when she started to develop asthmatic attacks as a defense and a weapon. She had had this illness first when she was 3. Shortly afterward her brother Michael, the fifth child, was born. Maria, until then called "Baby," became very jealous of the attention the new baby received. She tried to maintain her old status of having her parents' whole time and affection by having attacks of asthma—and found that it worked.

She ignored the baby completely, and his hatred of her became obvious. It is easy to see that this tension would in time have serious results. It did. Maria's attacks came more frequently and with greater intensity. Some member of the family had to get up to give her medication almost every night. Her physical condition became acute, and a doctor sent her to the children's hospital that was now asking foster care for her.

It is well known that jealousy of a newborn brother or sister is not unusual when mothers and fathers do not know how to prepare the older child for the new arrival. It can, of course, be overcome by wise handling of the situation when parents learn to show their affection equally and to bring disgruntled older children into the circle of their own enjoyment of the youngest one and into the fun it can be for a family to have a new baby. Unfortunately, Maria's parents—especially the mother—were too deeply disturbed themseves by their own problems to be able to help little Maria and Michael. What was their mother's chief problem? She was not, it was clear to the social worker, really acting as her children's mother.

Mrs. Angela Q., the mother, had come to the United States from Italy when she was 15 to marry her cousin, a fisherman. From the first she lived with her mother-in-law (her own mother's sister), who had been in this country a long time. Angela had not become grown up enough before marriage to sever her tie with her own mother and had immediately become a dutiful, pliant daughter to her mother-in-law in an adolescent way. This tie was still binding her, the mother of five children, while Maria was so acutely ill. The tie was a damaging one. The mother constantly had to give in to her mother-in-law about matters small and large—even about bringing up the children. The grandmother, without consciously realizing it, effectively turned the children's love away from their mother to her. She did this partly by insisting that the mother punish the children constantly for things they did and then solacing them, herself. When Maria began to use asthmatic attacks to gain attention—the grandmother encouraged this by her excessive concern and frequent expressions of sympathy.

All the members of the family were subject to respiratory infections, their colds and similar ailments appearing in time of emotional stress. The elder Mrs. Q. used her own symptoms as one way to control her daughter-in-law. She would keep the younger woman at home to attend to her invalid wants instead of urging her to go out with her husband as she had planned. So Maria's father and mother, who were exceedingly fond of one another and had similar recreational interests, could scarcely ever spend their leisure time together.

When it was first suggested to Mrs. Q. that Maria stay in a foster home for a time while she was being helped to overcome her difficulty with asthma, the mother was bewildered. She could not make up her mind about it. She was an extraordinarily hard-working woman, a good housekeeper, and a person of high ideals about the responsibility of parenthood. It was bitter for her to acknowledge the fact that she had been unsuccessful so far with Maria. She finally agreed to the placement because the foster mother who was proposed for Maria was a nurse; the mother had finally realized that the little girl was in danger if her attacks of asthma were not stopped, or at least lessened. Mrs. Q.

was willing to try care in a foster home because she had seen that Maria was well when she was away from home. So Maria went away from home again.

Now the foster mother and the case worker worked with Maria toward helping her to manage her own life in accordance with her age. The child had asthmatic attacks periodically for the first 7 months and also had bad dreams that awakened her. The foster mother, observing her closely, found that a *placebo*, that is, a preparation given merely to satisfy a patient, was as effective as medication for the attacks when Maria awoke at night.

The foster mother heard the little girl tell the other children, "I'm not punished at home because I'll have asthma." This habit of Maria's the foster mother began to change, gradually, by showing appreciation of positive accomplishments rather than showing undue sympathy for illness and allowing the avoidance of illness to be the basis for decisions.

Maria loved her foster mother and wanted to do things to please her, such as dressing and feeding herself. But sometimes she would slip back into her baby ways. She saw a crib being set up for another child and asked to sleep in it. She was allowed to do so but, in time, left it of her own accord, easily, because she wanted to seem more grown up. She developed a healthy appetite for natural, nourishing foods, a real advance. She became less remote and sullen, even livelier in her manner. She found new, interesting things to do.

The case worker and the foster mother worked together to help Maria. The episode of the crib had followed a conversation the child had had with the case worker about Michael on the way back to the foster home from a visit to the clinic. Maria complained that her "baby brother Michael" had once pushed her out of her crib. The case worker said she could understand that this would make Maria angry. Maria replied that she wished a baby girl would come into the family to push him out of his crib. It was after this conversation that she had asked to sleep in a crib and was allowed to do so until she was ready to leave it for a bed. While she was sleeping in the crib she began calling Michael "my brother Michael" instead of "my baby brother Michael," thus recognizing him as a person of 4 years of age. As time went on, the breach between them slowly healed. When they saw one another at Maria's visits to the clinic, they would start to play, scuffling together affectionately.

On another occasion the case worker remarked to Maria how much more grown up she was becoming, adding with a smile that Maria could show her foster mother how grown up she was by not waking her in the night. The foster mother, learning about this talk, made the most of it.

Meanwhile, the case worker was working with Maria's parents. The mother kept numerous appointments for interviews. They talked about Maria's progress, the mother taking up matters that were not clear to her. The case worker explained Maria's improvement, as the child responded to her foster mother's approval of gains rather than approval of illness. Sometimes the father came to the interviews also and he was much interested in this method of preventing Maria from having attacks of asthma, seeming to understand it well. The parents asked, practically, what they could do. After a while they made a plan based on this idea: "When we meet Maria on her visits to town for clinic appointments, we'll speak of her pretty hair ribbons, or her pink cheeks, or how tall she is getting, instead of asking, 'Have you been wheezing'? And we'll think about Michael too now: we'll love him and give him some of the attention he missed as a baby when we were so worried about Maria's attacks."

But the mother's struggle to become an adult emotionally and to take over the management of her children from her mother-in-law was not easy. The first time Mrs. Q. expressed her hatred for her husband's mother, early in the interview, she became so disturbed that discussion of this relationship had to be kept in abeyance for a while. Gradually, the mother learned to express her feelings and to make it clear that she really wanted help. She asked specifically about how to handle the three older children and began to develop happier relations with them. As she felt herself becoming a real mother rather than an adolescent who was dependent on her mother-in-law, she was able to talk about this long-time situation with greater ease and as a result lived more comfortably with the woman who had dominated her for so many years.

Now that Maria has been more than a year in the foster home, she shows progress in various ways. While waiting in the clinic to see the doctor she does not sit on her mother's lap long but soon jumps off to play. She loves school now and is doing well. Soon she may be able to make visits home. Eventually, when the family situation has changed more, it is hoped she will be able to go home to live and will stay well.

The efforts of the Children's Mission to Children to help Maria overcome a recurring illness illustrates one use of medical foster care. The experience of this little girl in living in a foster home under medical supervision and under treatment by a case worker while a change in the pattern of her family's living was being brought about shows what a children's agency specializing in medical foster care may accomplish. But the accomplishment depends on many factors. Among them are careful selection of situations in which improvement is possible and the ability of the parents to use case-work counseling to effect the change necessary.

What it takes

If we of the Children's Mission to Children were asked what was most important in *medical* foster-home care for children, we could not name one part of the care only. The principles of good foster-home care apply to this specialized work. The requisites of a good program of medical foster care are: (1) The team work of physician, nurse, foster mother, case worker, occupational therapist, and other specialists as their services are needed; (2) adequate compensation to foster mothers; (3) a planned program of activity in the group homes, especially in homes giving bed care, because children confined to bed have such limited contacts; and (4) case-work service that concentrates on family problems affecting the health of a child and on counsel to child and foster mother that will make the placement of children with medical problems bring the results hoped for.

ONE APPRAISAL OF THE EMIC PROGRAM

WE ARE QUOTING here, from the December 1949 issue of the *American Journal of Public Health*, a statement on the Emergency Maternity and Infant Care Program, which was administered by the Children's Bureau for 75 months—from April 1943 through June 1949.

"The termination of the EMIC program on June 30, 1949, closed a gratifying and encouraging chapter in the history of medical care in the United States.

"As our readers are aware, EMIC was a wartime program operated by the State health departments to give medical, nursing, and hospital maternity and infant care to wives and babies of enlisted men in the four lowest pay grades, about three-fourths of the armed forces. Funds were supplied by Congress through the Children's Bureau within the framework of the Social Security Act. The fact may not be clearly realized that, at its height, this program covered one out of seven of all births taking place in the United States. Its purpose was to give a serviceman assurance that his pregnant wife and his coming child would have good medical care, and that the cost would be paid for from general tax funds. Men returning from World War II did not face unpaid maternity bills as did those of World War I.

"It is probable that the most important long-range influence of the program was its emphasis on quality of care, which not only affected the mothers and infants who received direct services, but raised the local level of maternal and child care in entire areas, where the level had before been low.

"Minimum standards were established for hospital, maternity, and newborn services for the first time in many parts of the country.

"The EMIC medical advisory committees appointed by State and local health departments were a potent force in maintaining a high quality of medical care under the program by recommending standards of prenatal care, by establishing lists of consultants competent in various specialties, and by urging the general practitioners to call the consultants who were made available under the program.

"Many mothers whose husbands were not in service learned from EMIC patients what to expect in the way of good medical care throughout pregnancy, at delivery, and after the baby's birth. They learned for the first time what good health supervision and medical care for an infant really is.

"More widespread appreciation of the value of hospital care as a result of the EMIC program was partly responsible for the fact that in 1947 the proportion of births occurring in hospitals reached a new high of 84.8 percent, as compared with 72.1 percent in 1943, an increase of almost one-fifth. This occurred in spite of the great postwar rise in the birth rate and the shortage of new hospital facilities.

"All physicians were paid for their services, and though in some parts of the country the rates of payment were less than is customary in private practice, in other areas the rates were better than the prewar average. Hospitals were paid on a cost basis, and they—like the doctors—had no 'bad bills.'

"Since the principle was established under EMIC that payment by the State agency must constitute full payment to the hospitals and physicians, it was essential that rates of payment to physicians and hospitals be made equitable.

"The per diem cost formula for payment to hospitals was accepted, in general, to a surprising degree. Incidentally, the fact that there was no additional payment for surgery (such as Caesarean section) included in the program avoided any possible incentive to unnecessary surgical interference.

Every State had EMIC program

"One of the most amazing features of the EMIC was the facility with which every State health department established the machinery for administering this medical-care program, involving practically all physicians and hospitals in the State. Many of the patients were moving from State to State; and it was not found difficult to arrange for continuing care, since the programs, almost identical in scope, were in operation in all States.

"Although there were many complaints at one time about too much Federal insistence on reasonable uniformity of the State programs, most of the States welcomed the fact that they did not have to negotiate locally without full support of the Children's Bureau, with respect to the basic principles involved. The Children's Bureau, with the best medical advice it could secure, had, of course, to bear the ultimate responsibility of seeing that care was made available under conditions which were as equitable as possible to all concerned.

"The average cost during 1943–48 of EMIC maternity cases completed was $92.49 for medical and hospital care; and for cases of infant care completed it was $63.89. The $127,000,000 paid to State health departments bought for almost 1¼ million mothers and their infants the health supervision and medical care they needed. State health departments learned that the cost of administration in such a medical-care program was very low compared to the costs for service. Although accurate totals for State and local expenditures for administration have not been compiled, the States usually estimated them as considerably less than 5 percent.

"The Children's Bureau administered its responsibilities for the program with its small prewar staff, and it had no new funds except for three auditors rather late in the program. There is an immense amount of valuable factual information available to the State health departments which have the time and the money to finance the analysis of their medical and administrative records under the EMIC program.

"A few such studies have already been initiated. Public-health workers will find a mine of information about the administration of EMIC in the report of a study made by the School of Public Health, University of Michigan, while the program was in full operation. Dr. Nathan Sinai directed the study and reported his findings in *EMIC—A Study of Administrative Experience*. One of his conclusions summarizes well the administrative lesson to be learned from this wartime medical-care program.

"'EMIC serves as a striking demonstration of joint effort and of administrative resiliency. It would be hard to find another wartime program that grew to such comparatively huge proportions and still remained within the framework of an existing national, State, and local peacetime administration. The accomplishments in meeting the problems, disregarding the antagonisms, conflicts, and fears, are a monument to the combined contributions of medicine, public health, and the hospitals. Maternity and infant care were the goals; maternity and infant care are the achievements.'"

CHILD WORKERS

(*Continued from page 120*)

ardous employment; and, for a few occupations in which the child works outside school hours under specific safeguards, 14 years.

Employers can protect themselves from unwitting violation of the child-labor provisions of the Fair Labor Standards Act by making sure of their employees' ages. This can be done by obtaining State employment or age certificates for minors up to 18 years of age in general employment and also for those claiming to be 18 or 19 years old if they are employed in jobs declared by the Secretary of Labor under the act to be particularly hazardous. Such certificates can be obtained in most States from school officials or State labor-department officials. In four States, South Carolina, Mississippi, Idaho, and Texas, Federal certificates of age are issued through Wage and Hour and Public Contracts Divisions offices.

ED. NOTE.—*The Secretary of Labor administers the child-labor provisions of the Fair Labor Standards Act, and he has delegated to the Administrator of the Wage and Hour and Public Contracts Divisions the duty of making investigations to obtain compliance with these provisions of the act. To the Bureau of Labor Standards the Secretary has delegated the duty of developing child-labor regulations and of working with the States on their employment-certification programs where State certificates are accepted as proof of age under the Fair Labor Standards Act.*

• CALENDAR

Feb. 27—Child Study Association of America. Annual conference. New York, N. Y.

Mar. 12—Girl Scouts of the United States of America. Thirty-eighth birthday.

Mar. 12–18—Camp Fire Girls Birthday week. Fortieth anniversary.

Mar. 14–18—Play School Week. Annual conference of Play Schools Association. Information from the Association, 119 West Fifty-seventh Street, New York 19, N. Y.

Mar. 19–23—International Council for Exceptional Children. Chicago, Ill.

Mar. 26–30—National Society for the Prevention of Blindness. Conference in conjunction with the interim session of the Pan-American Association of Ophthalmology, Miami Beach, Fla.

Mar. 26–30—Council of Guidance and Personnel Associations. Annual convention. Atlantic City, N. J.

Mar. 27–30—National Vocational Guidance Association. Annual meeting. Atlantic City, N. J.

Mar. 29—Alliance for Guidance of Rural Youth. Atlantic City, N. J.

Regional conferences, Child Welfare League of America:

Mar. 9–11—Southern Regional Conference. Shreveport, La.

Mar. 16–18—Central Regional Conference (formerly called the Ohio Valley Regional Conference). Toledo, Ohio.

June 5–7—Midwest Regional Conference. Minneapolis, Minn.

Area conferences, National Child Welfare Division, American Legion

Mar. 3–4, 1950. Area C—Alabama, Arkansas, Florida, Georgia, Kentucky, Louisiana, Mississippi, North Carolina, Oklahoma, Panama, South Carolina, Tennessee, and Texas. Dallas, Tex.

Mar. 10–11, 1950. Area A—Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont. Hartford, Conn.

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What's Past Is Prologue

Workers for children feel that this country reached another milestone on the road to full child-labor protection, when the recent amendments to the Fair Labor Standards Act went into effect.

As Wm. R. McComb points out in this issue of *The Child*, young workers in a whole new field of interstate industry are now brought within the purview of the child-labor provisions of the Fair Labor Standards Act.

These provisions can now reach boys and girls employed in industries that the original act of 1938 could not reach—industries such as those carrying on transportation and communications, that do engage in interstate commerce, even though they do not produce goods for such commerce.

In addition, the new amendments prohibit employment of children in agriculture during school hours (except on their parents' farms) if the crops are for interstate commerce. This will open the way to more schooling for many migratory children and for other seasonal child workers on farms.

It was not until about the beginning of this century that public opinion began to organize on a broad scale to fight child-labor evils. But once we were well into the 1900's, milestones of child-labor progress were not far apart. In 1904 came the organization of the National Child Labor Committee. In 1906 the first Federal child-labor bill was introduced in Congress. A year later, in 1907, Congress authorized a Nation-wide study of woman and child wage-earners. Then, in 1912, the Federal Children's Bureau was established, and in 1913, the United States Department of Labor.

Passage of the first Federal child-labor law marked the year 1916. But progress was slowed when this law was declared unconstitutional. Then, in 1919, a Federal child-labor tax law was passed, and this met the same fate. In 1924 a Federal child-labor amendment was submitted by Congress to the States. In the meantime, many States improved their child-labor legislation, complementing and supporting Federal child-labor regulation. Thus State protection for child workers advanced more rapidly between 1910 and 1920 than in any prior decade.

In the second quarter of the century efforts to help working children ran into difficulties. The child-labor amendment failed of ratification, and the NRA codes, with their child-labor provisions, were cut short by an unfavorable Supreme Court decision. But before long a Nation-wide pattern of Federal protection for working children, under the Constitution, was set by the child-labor provisions of the Fair Labor Standards Act of 1938.

Now that this act has been amended to provide still more protection to employed boys and girls, we should congratulate all who were concerned in bringing about this forward step—the many public and private agencies that have worked to obtain the new amendments, as well as the Congress itself. Such an advance in child-labor protection is significant, not only because it prevents employment harmful for children, but because it helps to make it possible for our young people to achieve their own educational fulfillment and personal development.

But there is much more to be done. This new Federal action needs for its full implementation the support of State and private agencies and of the general public—employers, workers, parents. It should give impetus to advances in State standards, which cover not only interstate employment, but also intrastate, and which can regulate night work and other working conditions not within the orbit of the Fair Labor Standards Act.

This is a challenge to every citizen—to work for advances in the child-labor laws of his own State.

Katharine F. Lenroot

Chief, Children's Bureau

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Managing Editor Sarah L. Doran
Art Editor Philip Bonn

FEDERAL SECURITY AGENCY
Oscar R. Ewing, Administrator

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Arthur J. Altmeyer, Commissioner

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Katharine F. Lenroot, Chief

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the CHILD

WHEN A BABY DIES UNEXPECTEDLY

U. S. SUPERINTENDENT OF DOCUMENTS
MAR 28 1950

KATHERINE BAIN, M. D., *Acting Director, Division of Research, Children's Bureau*

EACH YEAR IN the United States a large number of babies under 1 year of age die of what is classified as "accidental mechanical suffocation." The story behind the death is usually this: An infant, in apparent good health and usually between the ages of 2 and 5 months, is put to bed in a crib or baby buggy, or in bed with his parents. Several hours later the infant is found dead. Sometimes he is lying on his face; sometimes bedclothes are over his head. Often in the excitement of the discovery the exact conditions are unnoted. The physician, the coroner, or the medical examiner, confronted with such a death, is likely to assume that the baby has smothered. And without an autopsy, or at best after a sketchy one, he writes on the birth certificate that the baby's death was due to "accidental mechanical suffocation." This story, appearing in the daily press, is a familiar one.

Was the baby neglected?

But the story does not end here. The mother and father of a baby who has died in this way develop a great sense of guilt, which may disturb their lives for years. Sometimes accusations of one parent about the carelessness of the other lead to quarrels and a breakup of the home. Occasionally local authorities, or friends or neighbors, may imply intentional neglect, or even homicide. The social and emotional repercussions of such an "accident" are therefore widespread and of great importance.

Taken at its face value, the situation would appear to call for a campaign to educate the public on methods of preventing these "accidents." In fact, that is exactly what happens. Great pressure is brought to bear on public authorities by parents and by physicians to publicize this condition and to suggest ways of preventing it. If these deaths were really due to "accidental mechanical suffocation," as the records state, such a campaign might lead to a solution of the whole problem.

But there is now abundant evidence that most of these deaths are not due to any external cause but may be the result of a sudden overwhelming infection with which a young baby is not able to cope. When a careful post-mortem examination is made, including microscopic study, evidence of infection is often found in the baby's respiratory tract, though sometimes elsewhere in his body, as in the membranes of the brain.

When a careful history is taken, information is often brought out concerning respiratory infection in the family, and there may be some indication that the baby himself had not been up to par.

About 15 years ago Dr. Sidney Farber of Boston reported two cases of infant deaths said to be caused by suffocation, both of which were discovered later to have been caused by streptococcus infection. Each of these babies was found dead in bed, and each was diagnosed by the medical examiner as having died from suffocation. In each of these cases the fire department had been called upon to try to resuscitate the "suffocated" baby. Both babies happened to be under the care of the same pediatrician, and in each case he requested that a post-mortem examination be given. The post-mortems showed that the diagnosis of suffocation was incorrect.

Unexpected deaths of babies studied

Others have reported similar experiences. The largest series of cases studied intensively have been those reported by Drs. Jacob Werne and Irene Garrow in New York City and Dr. W. H. Davison in Birmingham, England.

Drs. Werne and Garrow have reported upon 167 such cases. These include every baby under 1 year of age that died unexpectedly in New York City's Borough of Queens during a 15-year period. In not one case did their investigation show accidental mechanical suffocation of a healthy baby by bedclothes or other such means.

Each of the 167 infants had been in apparent good health and had been found dead in crib, carriage, or bed. All these deaths were of the kind that are ordinarily considered due to suffocation.

For about one-quarter of the deaths (43) the cause was established through autopsy without microscopic examination. Mastoiditis and otitis media accounted for most of these deaths (20). Among the other causes were bronchopneumonia, congenital heart disease, and meningitis.

Microscope shows abnormal conditions

In all the cases that were given complete microscopic examination (118) abnormal conditions were found, usually an acute inflammation of the respiratory tract but sometimes of some other organ.

An important point made by Drs. Werne and Garrow was that these lesions were not found in the tissues of 31 infants who had died of proved violence, about half of them from intentional smothering.

Furthermore, Drs. Werne and Garrow investigated the deaths of 67 babies who died, unexpectedly, in view of other persons, so that there could be no possible allegation of smothering. In these babies acute respiratory disease was found to be the usual cause of death, just as with the others who had been thought to be smothered.

With such evidence, it is clear why these doctors consider inaccurate all certifications of death by accidental mechanical suffocation unless an autopsy has been done. "Furthermore," they say, "we may consider as unsatisfactory all autopsies in which there was failure to examine the brain, the mastoids, the middle ears, and the neck organs, in addition to the routine dissection of the thoracic and abdominal viscera. We may also disregard all cases that have not had a complete microscopic examination." (The report by Drs. Werne and Garrow may be found in the American Journal of

Public Health, June 1947. Incidentally, they now have a new total of 200 cases.)

Dr. W. H. Davison, who is the coroner for Birmingham, England, reported (British Medical Journal, August 25, 1945) that in his area the number of deaths attributed to smothering dropped noticeably after such deaths began to be investigated regularly by pathologists. Such investigations began after a law had been passed, in 1926, giving coroners greater authority in ordering post-mortem examinations.

During the years 1938 to 1944, 318 deaths were reported to Dr. Davison as possibly due to suffocation. Post-mortem examination, however, showed that only 38 of these deaths actually were due to this cause. The remaining 280 deaths were definitely ascribed to natural causes, principally bronchopneumonia.

Unfortunately, in this country, these cases often do not come to autopsy. The physician who is called, or the coroner or medical examiner, is content with superficial examination. If he feels reasonably sure there is no evidence of foul play, he accepts the story of how the child was found, and at most does a gross autopsy. Since most of the cases show nothing on gross examination, the case is assigned incorrectly to "accidental mechanical suffocation."

The problem is no small one. In 1947 in the United States the number of deaths attributed to this cause was 1,663, or almost half of all accidental deaths under 1 year of age. In addition, there were 929 deaths of babies under 1 year that were attributed to diseases of the thymus, and many of these were probably from the same cause as the deaths attributed to "accidental mechanical suffocation." In the large group of deaths described as due to "ill-defined and unknown causes" (4,065) there may also be some of these same cases.

In spite of the evidence presented by Farber, Werne and Garrow, Davison, and others, physicians continue to make this incorrect diagnosis, coroners continue to accept it without a request for complete autopsy, and the public continues to press for action.

If the situation is to be improved, more data must be secured, based on careful examination of these cases by a variety of means, to determine the cause of death, and these data must bear the stamp of approval of an authoritative group. Then physicians, coroners' offices, and the lay public will accept the results of an investigation which has the backing of a group and is not the work of one investigator.

And what is the Children's Bureau's interest in this? The Children's Bureau has a very broad mandate from Congress—to investigate and report on all matters pertaining to the welfare of children. Specifically mentioned is the important problem of infant mortality. The question of babies' deaths attributed to smothering is a public-health problem of some magnitude. The deaths of a comparatively large number of infants are wrongly diagnosed.

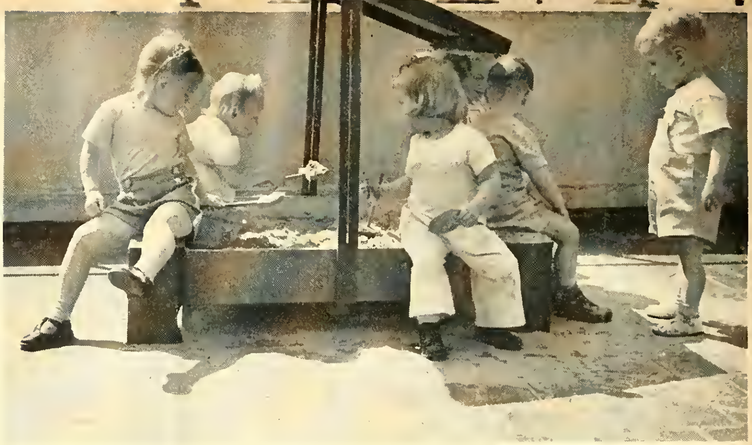
Like most young babies, this one is more comfortable sleeping on his stomach. A baby in this position is in no more danger of smothering than if he were sleeping on his back.

Accurate records essential

From the standpoint of advance of medical knowledge, the Children's Bureau is concerned with this error. It is concerned also in the correctness of vital statistics. Birth and death certificates are necessary tools used in improving the community's health, and it is essential that the basic data on these records be correct. As part of its interest in the social and emotional life of families and children, the Children's Bureau is concerned about the effect on parents of the feeling of guilt surrounding a baby's death that has been attributed to suffocation. And finally, the Children's Bureau is concerned to know how best to handle the pressure from the public, and sometimes from physicians, for propaganda based on the false premise that a baby is more likely to smother if he is sleeping on his stomach.

Recently the Children's Bureau, with the Public Health Service, both of the Federal Security Agency, called together a group of specialists—pediatricians, pathologists, and others—to consider the problem. This group proposed that what we know now be emphasized and highlighted for informing the professional groups concerned, as well as the lay public. But further, they said, we all need to know more. On the recommendation of this group there is under consideration the formation of a Commission for the Study of Unexpected Death During Infancy. Such a group might coordinate a series of studies set up in a number of cities, designed to investigate thoroughly all cases that would now be routinely classified as "accidental mechanical suffocation." Such a commission, after it had accumulated sufficient data on unexpected deaths, might issue a report, which because of the thoroughness of the study and the competence of the commission would be acceptable to the medical profession, to coroners and medical examiners, and to the public.

How one of New York's network of day-care centers works to help out families in its neighborhood



A DAY NURSERY GROWS IN BROOKLYN

PAULA LEVINSON, *Director, Child-Care Program, Young Men's and Young Women's Hebrew Association of Williamsburg, Brooklyn*

"WHEE!" In a corner of our nursery-school roof three little girls, with sunlight framing their hair, squeal their delight as they pump upward on the swings. In another corner of the roof a dozen boys and girls of 4 years or so are racing to the top of a steel jungle-gym that stands like a windmill against the sky.

Inside the nursery are more little tikes. Some are hammering away on peg boards, others fitting pieces of puzzles together. The older ones—first and second graders—are shouting orders to one another while constructing a miniature "brick" fortress.

Suddenly some one pushes the fortress and it collapses. Then comes a shout, "Look out, Mike! Falling bricks!" Mike throws himself flat on the floor, and a two-boy "ambulance" moves to the rescue, sounding its siren. At the wheel is the boy who had shouted the warning, and two "attendants" are gently placing Mike on an imaginary stretcher. Just another spontaneous, unrehearsed act.

This is typical of what you may see in a day nursery in any neighborhood in a city that is wise enough to provide this type of child care to its citizens.

The Williamsburg section of the Borough of Brooklyn, New York City, is such a neighborhood. And there you will find our nursery, which was started in wartime by a group of civic-minded women to provide all-day care to children of working mothers. Today, 5 years later, it is sponsored by the city's department of welfare and licensed by the department of health. That department's license, incidentally, carries with it approval from the fire department and the housing and building authorities.

The nursery is still located in its original home, the building of the Young Men's and Young Women's Hebrew Association of Williamsburg. And it still continues in human, neighborly fashion to give a hand to families in the neighborhood whose problems would overwhelm them if they had no place to turn for help. Many a family is still together because our nursery was here to give the children care during the daytime.

Families kept together

The fathers and mothers who come to us do not ask the nursery to take over their duties as parents. They ask us to care for their children during the day so that they may work to earn the children's living. If parents lack sound physical or emotional health, we refer them to the appropriate doctors, hospitals, or case-work agencies, meanwhile caring for the children.

When we admit a child, we know that his parents want our help, because they have asked us for it. And all that have come to us so far have come in time to be benefited by it. Even when there has been an actual break-down in a family, the resulting collapse was not so complete that the family could not respond to the help offered by the nursery and its social case worker.

We all know of cases in which a tragic beginning might have reached a happy ending if the family could have been given the temporary help it needed.

Most of our nursery stories do have satisfactory endings. Take, for example, the story of Marguerite.

Marguerite is a curly-haired, 3-year-old blond, with large brown eyes, full lips that turn up at the corners, and cheeks like rose-colored satin.

Marguerite's is not a tale of great distress. What happened in her family could happen in any family. Her father, a construction worker before the war, came home from his army service overseas to find that his former employer, a building contractor, had gone out of business. Marguerite's father, Mr. G, could find no other similar work because building had not yet started on a large scale. So her mother had to become the family's support. She went to work in a clothing factory. Then they began to think about how the father could be trained to enter a new line of work.

Mrs. G found that her boss needed workers; and the obvious step, Mrs. G felt, was to teach her husband her work—to become a sewing-machine operator. While Mr. G was learning, his wife would continue to be the breadwinner.

Fortunately for all concerned, Mrs. G's employer agreed with her. So did our counselor, a worker furnished by the department of welfare, whose duty it is to establish the family's eligibility for the child-care program. Marguerite could be admitted to the nursery. The counselor's report convinced us that this family needed our service and *could use it constructively*. And so the community, instead of putting the family on relief, took the responsibility for helping it to rehabilitate itself.

Mrs. G's earnings were decreased during the period of her husband's apprenticeship, for, naturally, while she was teaching him, her own work was slowed up. Marguerite took her share of the sacrifice, too. For her daily time away from home was 4 or 5 hours longer than any young child's should be; she was with us from 8 to 6 o'clock. At the close of a year, Mr. G had become an operator with enough wage-earning skill to support his family again. He came in to tell us this one day and to thank us for our help. "It's a good thing that my wife won't be working any longer," he said smilingly, " 'cause we're going to have another baby."

Two difficult children are helped

The R family has presented a more complex problem. But the improvement that has taken place in the family situation and in the relations of the two children with each other since they have been in the center is fairly typical of the results reached when families receive help in time.

Richard and John R are brothers, now 7½ and 4½ years old.

Since the birth of the children the father had been able to support his family working as a plumber, and the mother had not worked. They had some savings because the father had earned good money during the war. Then about a year ago Mr. R had a fall that injured his back severely. For a while he could not work, and for a full 6 months his doctor kept him from doing the hard manual work that went with his occupation. He could get no job that was easy enough. Meanwhile Mrs. R had gone back to the work she had given up more than 8 years before, work in a dress factory. Trying to get adjusted to work now that she had two active children and a disabled husband was a disturbing experience for her. The responsibility was great. It was hard to run the household on her $35-a-week wages; the family had to use some of its savings. Mrs. R struggled on because if she failed to hold her job she knew the family would have to seek home relief from the city department of welfare. At that time the doctor could not assure Mr. and Mrs. R that the husband would ever be able to resume his work as a plumber. Her anxiety and fearfulness about carrying so much responsibility affected the children.

At this point the mother learned about our nursery. She hoped that she could manage to be both wage earner and homemaker if the children were cared for during her working hours. So Richard and John were taken into our nursery.

Very soon it was evident to the director, the teacher, and the social case worker that the two little boys needed very much the kind of help the nursery could give. They were extremely difficult children, reflecting in their behavior their mother's tenseness and their father's unreasonable severity with them. Although the mother, according to her friends, had previously been a friendly, good-natured person, she had now become extremely short-tempered with the children—especially with Richard.

When the children were first at the nursery, the teachers reported frequently to the case worker that the children were an almost unbearable burden. They specified their complaints. When the case worker tried to talk with the mother about her sons' behavior she said that the stories could not be true. She was evidently afraid that we might drop the children from the center.

But finally she realized that the case worker did not want to make her give up her job and did want the children to stay in the nursery, but under happier conditions for them. She at last understood that the nursery's goal for her family was the same as her own; the nursery was trying to make it possible for the children and their parents to be happier together.

Having arrived at this appreciation, the mother looked again at our suggestions to help her have greater patience with the children, to control her temper with them, especially with Richard. Perhaps now she could begin to put the suggestions to work.

Hope depends on the mother

The case worker talked to the father at about this time. He showed little understanding of the problems of his wife and children or his part in them. He felt he was fulfilling his responsibility by taking home his weekly pay check.

When he heard the teachers' reports of how badly the two boys behaved, he was amazed. He replied that at home he wouldn't allow that; the boys always did what he ordered. Otherwise he would hit them and "there was no more trouble." It was clear that he managed his sons through fear.

The worker reluctantly decided that Mr. R's attitude toward his children could probably not be changed and that he could not learn that his treatment of them showed in their disturbed ways. The hope of helping Richard and John depended on the ability of their mother to change her treatment of them.

When it was clear that the mother wanted help and would concentrate her efforts on putting it to good use, a series of interviews was arranged with the case worker to cover 6 weeks' time.

How did the boys show their disturbed home life? Both children were excitable and "aggressive," especially Richard. They attempted to get what they wanted by force alone. Richard was always on edge, often stamping around, trying to get the teacher to do something for him. He could not play naturally with the other children. Instead he bullied and hit the smaller ones and, from a safe distance, called the older ones dirty names. The children, of course, seldom asked him to play with them. When the teacher did help Richard to get into some activity, he could not stay with the other boys and girls for any length of time. He spent his energy diverting the attention of the children from the teacher by yelling,

The primary service of a day nursery is to provide a useful social experience to the child.

whistling, or making "funny" gestures.

Johnny, 3 years younger, was not so serious a problem and did have some pleasant moments in the nursery. He was more friendly than Richard and at times played well with the other children. They liked him then. But not when he displayed his two great faults—his bursts of terrific temper and his riding roughshod over the rights of others. At these times he used to adadvantage his powerful little build in bullying other children. To get his own way he would hit boys and girls bigger than himself, and even the teacher.

The busy mother's interviews with the case worker meant a real investment of time, energy, and self-searching—never an easy experience for anyone to go through. The worker let her know indirectly that her sincerity, the desire she showed to understand herself, and the effect of her treatment of the boys was fully appreciated at the nursery and would have good results for Richard and John.

The interviews helped Mrs. R to begin to get rid of her anxiety and fear. She began to see that she was treating the two boys differently because she was fonder of John than of Richard. She saw that she had greatly feared having her first child and had been unsure of her early care of him. Gradually she had transferred this uncertainty to the child and, fearing something would happen to him as the result of carelessness, did not let him have any fredeom.

She did not trust Richard to make the smallest decision, and later she kept him from playing on the street with other children of his age. She told him in great detail just what to do about everything. When she was worried about money, about keeping her job, and about the children, she could not control her anger at Richard. Sometimes even on the street she would shout at him and hit him. Her anxiety about all this made it impossible for her to show any affection for the boy—in fact, she was not sure she had any.

When the second child came, she knew better how to take care of him physically and things went better. She loved Johnny and the boy knew this—only too well, sometimes. He would play on this affection to gain special privileges that had already been refused. Very early Johnny developed a terrific temper; he had unusual strength and fought for what he wanted. His mother did not know how to help him, with firmness, to recognize that other people also had rights and there were limits to what he, himself, could expect to have. She would now have to learn firmness, pleasantly applied. Then Johnny could enjoy the nursery most of the time instead of only between his tantrums.

But first came Richard's problems. As the mother was able to talk to the case worker with greater ease about her relations with her first-born she was able to put into effect some of the suggestions that came out of the interviews. She refrained from cautioning the boy about everything he did. Then, because he began to use his own judgment, he argued less with his mother. He also became noticeably friendlier at the center and seemed to have less need to bully the younger children. He is still a problem for the teachers, but he has made his first real advance.

One advance often leads to another. The boys' father has always thought one of his duties is to be the family punisher. Richard has thought of him chiefly as the person to administer "lickings," and hasn't liked him much. Now that there will be less need for punishment, better relations may develop between the two.

After a time, when the mother has learned to treat her two sons more fairly, with more adult judgment, the boys will probably get along better together. Richard will not be at such a disadvantage with Johnny and will not have to feel that he must fight for attention.

Now, in the first part of the second year since the children have been coming to the nursery, Mrs. R is still working, but she is now taking her job in her stride. The father has been working for 6 months or so but is earning only $50 a week. There is financial security in the home because of the mother's earnings, added to the father's. But the mother now wants Richard and John to stay in the nursery so as to have their chance to become real children like most of the other boys and girls there and to be welcomed into the nursery group. She intends to do her share to make this possible. Now when she comes to the nursery to get them she is less critical of their behavior. She says she looks forward to calling for them. Life at home, she seems to be saying, is no longer a constant battle between two grown-ups and two children.

Another of our children, 3-year-old David, is not likely to be with us as long as Richard and John. David is Marguerite's best friend. He has no problems that he knows about. He enjoys all the activities of the center that he takes part in. He gets along with his

3-year-old playmates. He sleeps soundly in the cool, quiet darkness of the room at nap time. But his mother has problems that the nursery's care of David is helping her solve.

David's mother has to be both parents to her little boy. She had married a young man employed in the office where she had begun work as a stenographer. Soon after they were married he was made a junior executive of his firm. He went by airplane on his first out-of-town trip in his new position and was killed when the plane crashed.

Until David's father's estate could be settled there was no money. His mother had to go to work again, and this time she found a position as a bookkeeper. She turned to the nursery for help—care of David while she was working. With the boy safely cared for in a good atmosphere each day, the young mother is recovering her sense of equilibrium and is learning to take on her new responsibilities.

When an income is assured from the father's estate, the mother can give up her office job and concentrate on being a full-time mother to David. Then David's place at the nursery will be given to another 3-year-old whose family needs the nursery's service.

Facts and figures

We feel that the day nursery is a community facility. Its primary service is to provide a useful social experience for a child. It should serve the families in the community who can benefit most from its service, regardless of a family's race, color, or creed.

Within this broad definition, a child-caring center can be as simple or as complex, as small or as large, as space and finances dictate. It happens that ours is "in-between," in size, with about 75 children enrolled, representing about 60 families. Of these families 12 have only one parent in the home, and 19 need the service because the mothers are incapacitated. In 28 families both parents must work to support the family; in 1 family the income jointly earned exceeds the department of welfare "ceiling," although the father's wages alone would not be enough to support them.

Fees range, throughout the city, from 30 cents to $3.10 a day for all-day care, including a hot lunch and two snacks, in accordance with a sliding scale set by the department of welfare. At our nursery these fees are from 30 cents a day to $1.15. (The family whose finances are adequate has been accepted as "ineligible" and pays the maximum rate of $2.17 for care of a school-age child.) All other families pay what they can afford, within the scale.

The staff of our nursery consists of 16 members, 12 working full time and 4 part time, and in addition a board member who is on call as a volunteer pediatrician.

The 16 members are: Two full-time administrators, a full-time counselor, a part-time case worker, 7 full-time educational workers (4 teachers and 3 assistants), a part-time assistant, a cook and a cook's helper, and 2 part-time maintenance workers.

The day-care center is operated in the building of the Young Men's and Young Women's Hebrew Association of Williamsburg, in Brooklyn. The "Y" has given over its entire top floor to the 3- and 4-year-olds. This includes a large playground on the roof, shaded during the summer and equipped with showers and with water-play facilities. It also has other play equipment, which will be mentioned when the program is discussed. On this floor are large indoor playrooms, with one complete wall of windows. The child-sized toilets are adjacent to the playroom. Here also are drinking fountains, easily reached by young children.

Five-year-olds and school-agers use the third-floor and second-floor playrooms that older groups use in the evenings. Both rooms are large, light, and well ventilated.

When schedules permit, "Y" facilities are open to children of the day-care program for special activities such as gym, rhythm, shop, and movies. Another connection between the Association program and the day-care center is the work that adult groups do for the center. For instance, members of various groups, including the old-age group, made houses for the day-care children's pets, clothes for their dolls, and furniture and other equipment for their "doll corners."

The program

As with all child-care centers supervised by the city department of welfare, our program is geared to maintaining a healthful emotional atmosphere for children whose lives at home need the kind of supplementation the center can give. We let a child know he is loved at the nursery and try to give him a feeling of stability in his contacts there.

We try to keep a strong tie between home and nursery. We provide opportunity for realistic play in which children can reproduce their home environments. "Doll-corner" play is a very important activity for the youngsters. We have a miniature reproduction of a city apartment, in which a child can cook, sew, care for her "babies," and entertain friends when the "man of the house returns from work." There are

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While mothers are at work, a neighborhood day nursery keeps the children happy and busy.

CHILD-LABOR LAWS; PASSED AND BYPASSED?

A survey of enforcement and administration of State child-labor legislation

SOL MARKOFF, *Legislation and Field Service, National Child Labor Committee*

LAST YEAR the United States Department of Labor reported that nearly 58,000 minors had been found illegally employed in violation of the child-labor provisions of the Federal Fair Labor Standards Act during the 10-year period that ended June 30, 1948. [1]

About 49,000 of these children, under 16 years of age at the time they were found employed, were working in jobs that illegally deprived them of opportunities for education, recreation, or rest.

The other 9,000 were 16- or 17-year-old boys or girls who, at the time of their employment, were found working unlawfully in particularly hazardous work which imperiled life or limb.

Such widespread illegal employment should serve as a sharp reminder that child labor is not a relic of the past but is a current evil of considerable proportions.

Behind the impersonal figures in the Federal Government's report are real children, who through one circumstance or another go to work before they are ready, in unsuitable or even harmful jobs; children whose futures may be blighted by the poverty, ignorance, and ill health that often result from too early or harmful employment.

Large as these numbers are, however, they do not even begin to tell the whole story about illegal and harmful child labor throughout our States. The Federal child-labor law, although Nationwide in its coverage, applies only to interstate industries. It does not apply to small local establishments, and it completely exempts children employed in agriculture when schools are not in session. Because the Federal law does not reach down into all the industries that employ child labor, hundreds of thousands of working children can rely only on their own State child-labor laws for protection.

In view of that fact it seemed desirable for the National Child Labor Committee to make an inquiry among the States about the administration of their own laws in order to gather information that would supplement the experiences under the Federal program.

Accordingly, in the fall of 1948, such an inquiry was made, by means of a questionnaire that was mailed to enforcement officials in every State. Not all the questions were answered, but the information that was supplied helps throw light on child-labor-enforcement practices in various States. We hope that the findings of this survey, summarized below, will help officials and others concerned with the problem to assess their own State's work in this field.

State enforcement agencies

The data indicate that 45 States vest the enforcement of child-labor laws in the State's labor department or industrial commission.

In only five States—all nonindustrial—are child-labor laws enforced by some other kind of governmental agency, having functions not primarily concerned with enforcing laws or with improving working conditions of wage earners. [2] In two of these jurisdictions, Mississippi and the District of Columbia, there is no labor department of any kind. In each of the other three, Idaho, New Hampshire, and New Mexico, there is a labor bureau or an industrial commission; but enforcement of the child-labor law has been assigned to some other division of the State government.

It is evident that most of the States, however, find that the child-labor laws can most appropriately be enforced by an agency with a comprehensive and integrated labor program rather than by the board of health, the public welfare department, or the State school system. The effectiveness of this widespread practice serves to suggest the desirability of its further extension to the few States that at present either do not have any labor department or have a different kind of enforcement body.

According to the information received from 41 States, [3] only 11 of the enforcement agencies have one or more child-labor specialists whose full time is devoted entirely to the enforcement and administration of the child-labor law. [4] In most States the officials, in addition to their child-labor work, may also be charged with the responsibility for enforcing and administering other labor laws.

Although to have a separate inspection staff for each function might be more costly, and might result also in an annoying multiplicity of inspections, it might be sound policy to have on the staff, on a supervisory level, a child-labor specialist whose sole concern would be the child-labor program. Such a specialist might be responsible for planning child-labor inspection, for the training of personnel in special inspection techniques, and for community relations.

Child labor can be a complex affair, and it is not always simply a labor problem that can be settled as soon as an employer has agreed to comply with the law. The child worker found illegally employed may need help in solving the individual problems that led him into illegal employment in the first place.

An effective child-labor program often requires the closest cooperation between the labor department, the schools, certificate-issuing offices, youth-employment services, and welfare agencies in the community. The necessary liaison between these agencies might more easily be established by child-labor specialists whose interests and professional training could insure development of a sound framework for cooperation.

This 16-year-old is evidently too young to feel responsible for wearing his goggles to protect his eyes while he is using a welding torch. In some States the child-labor laws try to prevent this situation by setting 18 years as the minimum age for employment as a welder.

Inadequacy of staffs

According to the data supplied by 38 States, more than 70 percent of these believed that they were insufficiently staffed with inspectors and that as a consequence they were handicapped in enforcing their laws. [5] This conclusion represents the reasoned opinion of State administrators who have to work with their limited forces day after day. It is not surprising, therefore, to find that few prosecutions are being undertaken by State officials against violators of child-labor laws.

As one administrator put it: "The small staff we have makes it impossible to devote more time and attention to this vital and important duty. As it is, the child-labor prosecutions are the result of the work of our inspectors after their day's work on safety and on weights and measures. It is an imposition to expect our men to continue to work both day and night."

And as another official said: "* * * with only four inspectors to cover the State, it is impossible to make the number of inspections required to insure full compliance with the law. During the past year two boys under 14 years of age were known to be killed while employed * * *."

These observations emphasize how dark the present situation is for those employed children and young people who are being denied the full protection promised them in child-labor statutes.

Principal types of child-labor violations

From the data supplied by 22 State officials, a clear picture emerged, which showed the same characteristic pattern of violations occurring in one State after another. [6] Employment of children without working papers was the most frequent kind of violation reported by 18 of the 22 States. Many of the minors employed without certificates may very well be of legal working age, and their working conditions may conform in every way with all other requirements of labor laws; but if we look at the purposes of employment certificates, we can understand how erroneous it would be to look upon such violations as technical offenses only.

A good employment-certification system can be an effective barrier against illegal employment. It helps weed out those minors who are too young—or who are physically unfit—for certain kinds of work and thus serves as an important means of preventing illegal child labor before it actually begins. This is especially important in view of the lack of personnel for adequate inspection coverage. Equally important, since the certification agency is usually in the educational system, the requirement for an employment certificate gives school counselors an opportunity for exploring every possible resource for holding minors in school, even though they may be old enough for legal employment.

And in the case of a boy or girl seeking part-time work after school hours, the school authorities can see that the job is not one that would interfere with the young person's education.

If the certificating system is bypassed by the minor, the employer risks employing a child too young—or unfit—for work, and also the school loses an opportunity to see what, if anything, could be done to help the youngster from dropping out or from taking a job that would interfere with his studies.

The fact that so many States still find so many minors employed without certificates emphasizes the need for further educational work with minors and employers to impress upon them the importance of employment certificates.

Nighttime employment by young boys and girls was reported to be one of the principal types of violations in 18 of the 22 States that supplied data on this point.

Another practice, equally serious in its harmful effect on the health and welfare of young workers, is employment for excessively long hours, and this type of violation was among the three that occurred most frequently in one-third of the States reporting.

Children employed at night or for long hours are deprived of opportunities for needed rest, sleep, recreation, or study. They are particularly prone to injuries on the job because of fatigue. By working at night, they miss out on a normal home life, and sometimes in the course of such employment they are exposed to an unwholesome environment that may have destructive influences upon them.

Employment of young children who were under legal working age for the jobs they held was reported by more than half the States as one of the most serious types of offenses. These children may have dropped out of school before they were old enough to do so according to the provisions of the State's compulsory-attendance laws, or they may have been working during, or outside of, school hours at occupations prohibited for young children.

In nearly all cases, children involved in violations of this kind are also employed without employment certificates, or at least, contrary to the terms of a certificate. The fact that so many States expressed concern with violations involving under-age children points up the need for improving employment-certificate procedures so that violations can be prevented. It also emphasizes the need for close cooperation between the various types of agencies mentioned previously, to see whether such children might be redirected back to school or into a field of employment that is legal and is less harmful for them.

Another type of violation, though not so numerically widespread as the others mentioned, is, nevertheless, so serious as to warrant our attention. This is employment of boys and girls in occupations that have been found to be particularly hazardous for young workers.

Only 6 of the 22 States reporting stated that this was one of their principal kinds of violations, but it must be remembered that only a few State laws contain adequate safeguards in this respect.

Even though a relatively small number of States expressed concern over this problem, this is not entirely indicative of its extent and severity. Young workers are far more susceptible to industrial injuries than are adults, and no effort should be spared by child-labor-enforcement agencies to compel the strictest compliance with the laws designed to safeguard boys and girls against injuries.

Principal violators of State child-labor laws

The principal violators of State child-labor laws, according to the data supplied by State officials, are bowling alleys, mercantile shops, and service establishments.

When a child is dismissed because he has been illegally employed, what is the next step? He is likely to need help in solving the problems that led him into illegal employment.

We should not assume, however, that manufacturing industries are relatively minor offenders, for State labor departments may tend to emphasize inspections in nonmanufacturing industries.

As one State official put it: "Because concerns that are in interstate commerce and are subject to Federal child-labor laws are inspected by Federal agencies, which report to us any violations of State child-labor laws which they discover, it has been our policy to direct our inspection program primarily toward those which are not covered by Federal law."

If this official's policy is typical of others', this would help to explain why so many other State officials omitted factories from their list of the greatest child-labor offenders.

In considering this question we need to include the findings of Federal investigators. According to their experiences, manufacturing establishments outnumbered nonmanufacturing establishments in violations by more than three to one, even though the number of inspections in the two types of industries was approximately equal. [7]

Salaries of child-labor inspectors

According to the data supplied by 25 States, child-labor inspectors' salary schedules vary considerably. In four-fifths of these States, inspectors earn less than $50 a week; in one-third of the States, less than $40.

Although small increases are granted at periodic intervals, there is not much difference between the minimum and maximum salaries in any grade, and after many years of service an inspector may not earn appreciably more than he did when he began.

This situation is not calculated to attract or retain the competent and qualified professional personnel needed for the program. Half the State administrators from whom data were obtained felt this shortcoming acutely and reported that present salary levels were inadequate to hold the trained personnel they need.

The conclusion is inescapable that the salary scales for inspectors are too low, that they contribute to high turn-over, that they are a source of dissatisfaction to staffs, and that they handicap effective administration of State laws.

Entrance salary of State child-labor inspectors (per week)	*Number of States*
Under $35	2
$35–$39	6
$40–$44	5
$45–$49	7
$50–$54	2
$55 and over	3

Based on data obtained from Alabama, California, Colorado, Connecticut, District of Columbia, Illinois, Kansas, Kentucky, Maine, Maryland, Michigan, Minnesota, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, Texas, and Wisconsin.

Civil-service status of inspectors

To some extent the relatively low salary paid a child-labor inspector is offset by the security of employment that comes with civil-service status in some States.

Data obtained from 26 States and the District of Columbia indicate that in 16 of these jurisdictions inspectors who enforce child-labor laws are appointed under civil-service laws. [8]

The system of competitive examinations under a civil-service merit system is designed to insure selection of candidates best qualified to perform a job and is obviously superior to other systems. Extension of the merit system to all labor inspectors in all the States would seem to be a forward step in administration of child-labor laws.

Qualifications of inspectors

Reviewing the data supplied by State administrators, we find that the well-qualified inspector is considered by them to be a worker who has been trained in, and has had considerable experience in, legal techniques, accounting methods, economics, labor relations, and industrial engineering. These qualifications reflect the varied functions of the inspector. Usually, he not only is a child-labor inspector, but also may be called on to enforce a variety of laws, ranging over such diverse subjects as minimum wages and factory safety, and in some instances he must undertake to mediate disputes.

But as far as child-labor law administration is concerned, a background of law and accounting may not necessarily be a particularly valuable asset. The preferential consideration given candidates with such training, however necessary the training may be, seems to indicate that administration of child-labor laws may have a subordinate role in some State labor departments.

It may be just as important for a child-labor-law enforcement official to know the needs and drives of young people as it is for him to know, for example, the principles of pay-roll examination. It may be just as essential for him to know which resources could be tapped to help the child worker as it is for him to know how to prepare a legal case. It may be just as important for him to know how to counsel a child worker as it is to give an employer a legal opinion.

Labor departments concerned with improving the quality of their services in child-labor-law administration might give some thought to the selection of personnel whose training, experience, and interests qualify them to deal with young people. Since child-labor-law enforcement officials perform so many other functions, they undoubtedly do need a background in economics, labor relations, law, and accounting. And while separate child-labor-law enforcement staffs might be uneconomical, a way out of the dilemma might be found by having in-service training programs for general inspection personnel engaged in the child-labor program in order to equip them with some of the fundamental skills necessary for dealing with young people.

Principles for regulation of child labor

After reviewing the current situation as reported by the various States, it may be well to restate some basic principles commonly accepted as essential to the most effective protection of working children:

1. The administration of child-labor laws can be made meaningful in the first instance only if there is an adequate law to enforce; a law that promotes educational opportunities for all children, safeguards them against industrial hazards, and assures them sufficient time for recreation, study, rest, and other wholesome activities necessary for normal growth. Such a law would incorporate these standards:

During school hours a 16-year minimum age for employment for all children without any exception at all.

Outside school hours and during summer vacation a 14-year minimum age for employment.

A 16-year minimum age for employment in factories and mechanical establishments at all times.

An 18-year minimum age for work that is particularly hazardous.

A maximum 8-hour day and 40-hour week for all minors under 18.

For 14- and 15-year-old school children, not more than 3 hours a day and 18 hours a week of employment during the school year.

For 16- and 17-year-old school children, not more than 4 hours a day and 24 hours a week of employment during the school year.

Prohibition of employment after 6 p. m. and before 7 a. m. for minors under 16; and, for 16- and 17-year-old minors, no employment after 10 p. m. or earlier than 7 a. m.

2. The child-labor law should be more than a declaration of intentions. It must be enforced and administered with vigor and intelligence, with sincerity of purpose, by trained personnel, and with sufficient funds to do the job well.

3. A labor department with a comprehensive program of research, law enforcement, and promotion of standards is the best agency of government for enforcing a State's child-labor law. States that now do not have a department with such a program should consider the desirability of establishing one. States that now have labor departments, but without responsibility for administering the child-labor program, should consider transferring that activity to the labor department.

4. Child-labor administration in a labor department should not be relegated to a subordinate position in the affairs of the agency. Labor departments should consider the advisability of having on their staffs specialists on a supervisory level who would work exclusively on the child-labor program and who would be responsible for program planning, personnel training, in-service institutes, community relations, and integrating the child-labor program with the other functions of the agency.

5. Prevention of child labor is even more effective than detection. The States should review their employment-certificating procedures to see how they can be improved, modernized, and freed

of loopholes and red tape. The preventive part of child-labor administration should include the large-scale distribution of attractively illustrated and easily understood materials on the provisions of the State's child-labor law.

6. There should be established in the State a good framework of cooperation between the labor department, certificate-issuing offices, the school system, youth-employment services, and community agencies, to deal with problems that give rise to illegal child labor.

7. For a larger inspection program, staffs should be enlarged and sufficient funds appropriated. The size of the staff and the amount of funds necessary will vary from State to State, depending on the number of establishments and the number of working children, but there should be enough inspectors to permit immediate investigation of all complaints, spot checks in selected areas and industries, and periodic inspections of other establishments.

8. Program planning should be determined as scientifically as possible, and inspections scheduled at the times when, and the places where, children are at work. This may mean more night patrols by inspectors and more investigations of establishments not subject to the Federal law or other labor laws in the State.

9. The full force of legal authority, including prosecutions, should be exerted against repeated offenders, particularly those who employ children illegally in extrahazardous work. More attention might be given to safety inspections as a means of cutting down on the number of industrial injuries.

10. Salaries of inspectors should be increased to the point necessary to attract and hold the trained personnel needed to insure a successful program. What that point should be will vary from one State to another. The many State administrators themselves who felt that present salaries were inadequate are in a better position to determine what increases are necessary, and they should use their full influence to obtain an upward revision of the salary schedules. Civic groups, once informed of the facts, could be relied on for their strong support.

11. Extension of the merit system to all State labor-department inspectors should help obtain a better-qualified staff and should insure an administration that is freer of political pressures.

12. Selection of personnel whose work includes child-labor investigations should not necessarily be weighted heavily in favor of candidates with a legal or accounting background. In selection of a staff, persons trained or experienced in guidance, counseling, social welfare, youth service, or education might be favorably considered, since they possess the kind of background and interests that could prove a valuable asset in any program which seeks to serve the needs of young people.

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1. United States Department of Labor: An Evaluation—the Fair Labor Standards Act—1938–48; 1948 annual report of the Wage and Hour and Public Contracts Divisions, pp. 33–35. Washington.

2. Enforced by the education department in Idaho, New Hampshire, and the District of Columbia; by the board of health in Mississippi; by the department of public welfare in New Mexico.

3. No information from Arkansas, Delaware, Florida, Iowa, Missouri, Virginia, West Virginia, or Wyoming.

4. Alabama, District of Columbia, Indiana, Kansas, Maine, Maryland. Michigan, New Hampshire, Oklahoma, Tennessee, and Texas.

5. Additional inspectors were reported as needed in Alabama, Arizona, Illinois, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Montana, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, South Dakota, Tennessee, Texas, Utah, Washington, West Virginia, Wisconsin, and Wyoming.

No data were received from Arkansas, Delaware, Florida, Georgia, Idaho, Iowa, Mississippi, Missouri, Nevada, South Carolina, or Virginia.

6. Based on data received from Alabama, California, Colorado, Connecticut, District of Columbia, Indiana, Kansas, Maine, Maryland. Massachusetts, Minnesota, Montana, New Hampshire, New Jersey, New York, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, Texas, and Wyoming.

7. According to the 1948 Annual Report of the Wage and Hour and Public Contracts Divisions, United States Department of Labor, 1,081 out of 14,580 manufacturing establishments were found in violation, and 303 out of 14,444 nonmanufacturing establishments were found in violation. Although it appears from these figures that violations in manufacturing establishments were proportionately greater than in nonmanufacturing industries, the statistics are not necessarily conclusive on this point. In the nonmanufacturing group many of the establishments may have been inspected for wage violations only, because of lack of child-labor coverage. The statistics take no account of that fact, but if they included such establishments, the overall percentage of child-labor violations in the nonmanufacturing industries would undoubtedly be higher than was shown.

8. Based on data obtained from Alabama, California, Colorado, Connecticut, District of Columbia, Illinois, Kansas, Maine, Massachusetts, Maryland, Michigan, Minnesota, New Jersey, New York, Ohio, Wisconsin, Arizona, Kentucky, Montana, New Hampshire, New Mexico, North Carolina, North Dakota, Oklahoma, Oregon, Rhode Island, and Texas.

DAY NURSERY

(Continued from page 135)

also opportunities for creative work with paint, clay, and wood, and for building with blocks. Neighborhood trips all year round are a part of our program and, for the older children, additional all-day outings during school vacations.

Health inspection starts the day. A daily rest, lasting from 1 to 2 hours, is arranged for the nursery children all year and for school-agers on school holidays. Good food habits are stressed.

In good weather during the winter, the nursery-age children play at least 2 hours on the roof—on slides, swings, walking boards, climbing apparatus, "loop-the-loop," and with outdoor blocks, sleds, and wagons. The older children play active games on our play street (a city block closed to traffic) or in the park. During the summer, in addition to regular outdoor play, we continue on our roof the activities that usually take place indoors—for example, weekly assemblies. The daily program for our children winds up with quiet, end-of-the-day enjoyments like listening to music or stories and singing.

Parents join in the program

In another part of the program the staff works and plays with the parents. Parents take the responsibility for raising money to purchase items that are beyond the nursery's budget. These items include books, doll-corner equipment, and tropical fish. Parents also work to get public opinion to support the day-care-center program so that it may continue uninterrupted.

Last year parents spent considerable time acquainting themselves with the functions of all the workers needed in running a good day-care program. They held evening meetings. A consultant for the day-care division of the department of health was one of the speakers at a parents' meeting. At other meetings the case worker, the pediatrician, and the counselor on the staff of the department of welfare spoke. The director is present at all such meetings, and the teachers are always at hand. This year parents and teachers are planning workshop sessions that follow up the various activities the children are engaged in.

In New York City the department of health determines the number of children a given center is equipped to serve, on the basis of floor space. The department of welfare checks on the eligibility of the families to service. Its counselors interview the families who apply for admission and make whatever home visits are necessary. Their consultants supervise the directors of the centers.

One thing is sure. There are never enough vacancies in the centers—that is the way it is in day-care centers everywhere—for the numbers of children whose families would like to have the service. Hence a system of priority rulings, recommended by the department of welfare and adapted to the situation in each community has become a part of the centers' policies of deciding about applications. All five priorities presume that nursery care will benefit both child and family. They are:

1. Children whose mothers are their sole or principal support and are working for remuneration in aid of their support.

2. Children whose mothers are dead, or incapacitated to care for them.

3. Children whose fathers and mothers must work for remuneration in aid of their support in order to maintain, without public assistance, a decent standard of living.

4. Children in families receiving public assistance whose mothers are working for remuneration in aid of their support.

5. Children who for any other reason are necessarily without adequate care in their homes during a substantial part of the day.

The details about the Williamsburg Day Nursery are not meant to be a blueprint for planners in other communities. They merely tell the practical story of how our community has tried to develop its own service as one part of the city's many-angled program of child welfare. Any neighborhood, anywhere, could do the same, on a proportionate scale. All it needs is high citizen-interest and a nursery committee that is intelligent, earnest, and tireless in its efforts to keep the center working well. To be sure, that is asking a great deal—more than it sounds. But after all, the efforts are for the families of the neighborhood—and they *are* the neighborhood.

• IN THE NEWS

Children's Fund Outlines Program Planned for Asia

India's rural areas will soon be visited by two United Nations-sponsored theaters on wheels, the United Nations International Children's Emergency Fund (UNICEF) has announced.

The project, in connection with a program which the Indian Government has undertaken, is one of the first approved under UNICEF's extended program of aid to the needy children and expectant and nursing mothers of Asia.

The theaters will consist of motor vans, equipped with moving-picture projectors, record players, and public-address systems, and will be used to spread factual information on child- and maternal-health care.

Other programs, including training of child-care experts and health education for mothers and teachers, have been approved for China; Indonesia; Japan; Pakistan; the Philippines; Thailand; and the British territories of Hongkong, Brunei, Sarawak, and Singapore. In the Philippines, for example, school lunches will be provided in areas where malnutrition is the No. 1 health problem.

Operations under way for India, Pakistan, Ceylon, and South East Asia call for a UNICEF contribution of $9,300,000 for supplies and training purposes. This sum forms part of an over-all budget of $20,000,000, which embraces China, Japan, and Korea, and which has been approved by the Fund for expenditure in the Far East and will be matched by contributions from the governments receiving help.

New York State Requires Reporting of Cerebral-Palsy Cases

Physicians in New York State, outside New York City are now required to report cases of cerebral palsy, under a State law that went into effect January 1, 1950.

The legislature acted on the recommendation of the Joint Committee Studying Cerebral Palsy.

The need for accurate information on the number of victims of this disease had been stressed by the committee as a step in drafting a broad health program looking toward State assistance for persons who are cerebral-palsy cases.

The cases must be reported to the city, county, or district State health officer. The law requires the reporting of cases under a physician's care if the patient is under 18 years old and the reporting of all new cases, regardless of age.

It is expected that New York City will eventually be included in the mandatory reporting.

Young People at Work

Slightly more than 2 million boys and girls 14 through 17 years of age were employed in November 1949, according to estimates by the Bureau of the Census, Department of Commerce. About one-third of these were working in agriculture, the rest in other industries. The total number employed was smaller by 140,000 than it was in November of the previous year, but almost as large as it was at the time of the 1940 census. The number of employed 18- and 19-year olds was 18 percent greater than it was in 1940.

Tenth Pan American Child Congress Convoked

The Tenth Pan American Child Congress will be held at Bogota, Colombia, in 1952, according to a resolution adopted October 11, 1949, by the Council of the Organization of American States. The Council will request the Government of Colombia to set the date in 1952 that it deems most convenient for holding the Congress.

The Council also authorized the Secretary General of the Organization to collaborate with the Government of Colombia and with the American International Institute for the Protection of Childhood in preparing for the Congress, and to transmit the official invitations to the countries that are members of the Organization.

The term, Organization of American States, was adopted to take the place of the term, Pan American Union, after reorganization of the Inter-American system at the Ninth International Conference of American States, held at Bogota in 1948.

Previous Congresses have been held at various American capitals, as follows: At Buenos Aires, Argentina, in 1916; at Montevideo, Uruguay, in 1919; at Rio de Janeiro, Brazil, in 1922; at Santiago, Chile, in 1924; at Habana, Cuba, in 1927; at Lima, Peru, in 1930; at Mexico City, in 1935; at Washington,

D. C., in 1942; and at Caracas, Venezuela, in 1948.

At the Pan American Child Congresses the various countries represented have exchanged ideas and experiences regarding services for children in the fields of health, education, and welfare. And the Congresses have made recommendations that have had a marked influence upon development of legislation in the American countries, and upon services for children under both public and private auspices.

Child Cotton Pickers Returned to School

During the 1949 cotton-picking season about 150 children in 8 Alabama counties were found picking cotton in violation of the child-labor provisions of the Fair Labor Standards Act. Many of these boys and girls were returned to their classrooms as a result of a series of investigations by the United States Department of Labor's Wage and Hour and Public Contracts Divisions.

Action was taken by the Divisions after complaints were made to the Birmingham regional office by school officials who had been alerted on the act's child-labor requirements through the Divisions' educational program. Three of the employers involved have been enjoined from further violations of this type by Federal courts in Alabama.

In advance of the picking season, the Divisions had publicized the 16-year age minimum set by the act for employment of children in picking cotton while they are legally required to attend school. The Birmingham office sent news releases to county school officials and to local papers in counties where cotton is grown. School officials cooperated with the Divisions in making the act's child-labor requirements known. In one county, the school-attendance supervisor arranged radio broadcasts of the release. She also sent copies to all county principals, who read it to their students during assembly periods.

The Divisions' subsequent investigations in eight counties revealed that many farmers kept their own children in school while employing other boys and girls to pick cotton.

Many of the children who were employed although they were under 16 were very young—of more than 100 who were under 14 years of age, half had not yet reached 12 years. Several were only 7 or 8 years of age. One was only 6.

Long hours for these young workers were common. Some children told wage-and-hour investigators they worked from 7:30 in the morning until 5:30 or 6 o'clock in the evening.

On 33 of the 50 farms where investigations were made, all the children employed were white. Negro children only were working on 15 farms, and children of both races on 2.

International Organizations Fight TB in Children

Two United Nations agencies—the World Health Organization (WHO) and the International Children's Emergency Fund (UNICEF)—have announced that as a result of their joint world-wide campaign, some 18,000,000 children have been tested for tuberculosis in Europe, Asia, and Africa. In addition, more than 8,000,000 have been immunized against tuberculosis.

• FOR YOUR BOOKSHELF

EARLY SCHOOL LEAVERS; a major educational problem, by Harold J. Dillon. National Child Labor Committee, 419 Fourth Avenue, New York 16, N. Y., 1949. 94 pp. $1.25. (5 to 9 copies $1 each; 10 or more copies 85 cents each.)

This report is based on information from school records, teachers, and boys and girls who left high school, in two cities in Ohio, one city and one county in Michigan, and one city in Indiana. Although the author's over-all finding that there is a 50-percent loss to the school of students between the ninth and twelfth grades is not new, it does serve to remind us once again of the unmet educational, guidance, and placement needs of boys and girls who leave school early.

Some widespread misconceptions concerning why young people leave school are effectively contradicted. We learn, for example, that 70 percent of these school leavers did not come from broken homes. And 88 percent came from homes where English is the predominant language.

Nor can we comfort ourselves with the assumption that the boys and girls who leave school do not have the mental equipment to succeed in school. Over 39 percent of the boys and girls studied had IQ's of 95 or better, a mark that is regarded by most authorities as sufficient for completing 12 years of schooling as it is now constituted.

Discouragement, frustration, and a feeling of not belonging in the school system did, however, seem to be important factors in school leaving. Symptoms of these factors, the study points out, can be found in records of poor attendance, of failures in the work, of transfers from school to school, and in other indications of poor adjustment to the school situation.

Mr. Dillon points out that these young people cumulatively constitute an increasingly significant portion of tomorrow's adult citizens and that their attitudes toward public education may now, and in the future, have much to do with the inability of schools to offer the kind of program that the early school leaver most needs.

The facts brought out here have been known by many people in and out of public education for some time. However, it is helpful to have a fresh statement of the facts and a more complete set of recommendations for meeting the problem. Most of the conclusions and recommendations bear on the need for a more individualized school program and a greater tie-in with real life situations, indicating that those who advocate life-adjustment education are on the right track. The National Child Labor Committee deserves much credit for facilitating the author's effort to set forth the facts so simply and to offer with emphasis some of the necessary solutions.

Charles E. Odell

THE COMPLEAT PEDIATRICIAN; practical diagnostic, therapeutic, and preventive pediatrics, by W. C. Davison, M. D. Seeman Printery for Duke University Press, Durham, N. C. Sixth edition, 1949. 256 pp. $4.75.

This unique reference book, first published in 1934, has recently appeared in a sixth edition, bringing up to date the information it formerly contained and correlating the newer advances with the preexisting knowledge. That the supply of the previous editions were rapidly exhausted attests to the popularity and usefulness of such a comprehensive yet brief digest of pediatric information.

The latest advances in medical knowledge, gleaned from nearly 2,500 additional articles, have been interwoven into the text, which remains the same in basic material and arrangement as former editions. The book emphasizes the twofold nature of pediatrics: (1) The appraisal of normal children and the necessity of keeping them normal, based on a knowledge of growth and development of the children, and prevention of disease, and (2) the recognition of ill children, their diseases, and what to do for them.

The Compleat Pediatrician, 1949, should be of practical value to medical students and to practicing physicians, who use it as a "ready reminder," and who, following the advice of the author, carry it like a stethoscope in pocket or bag.

Alice D. Chenoweth, M. D.

FEE CHARGING FOR ADOPTION SERVICE; a discussion of philosophy and practice based on a study of current practices among member agencies of the Child Welfare League of America, by Eilene F. Crosier. Child Welfare League of America, 24 West Fortieth Street, New York 18, N. Y. November 1949. 16 pp. 40 cents.

This study is based on reports from 46 of the 89 agencies listed in the 1948 Child Welfare League directory as offering adoption service. Fifteen of these agencies were charging fees for adoption services in July 1948, and 31 had considered or were considering fee systems. The study gives only the information received from the 15 agencies actually charging fees.

A CHILD'S EYES, by Richard G. Scobee, M. D. C. V. Mosby Co. St. Louis, 1949. 109 pp. $2.

Although the title of this book is a general one, the book itself is devoted to the subject of cross-eye in children.

Parents of a child with crossed eyes turn to a variety of persons, seeking answers to their many questions. To give satisfactory answers requires not only detailed knowledge, but also more time than is likely to be available. And even with knowledge and time, it is difficult to describe in understandable terms the mechanism by which the eyes function as a team and how this mechanism grows and develops in infancy and early childhood; what may go wrong to cause the eyes to cross; what methods of treatment are available and what may be expected from each. There is the added difficulty that a complete explanation is more than can readily be absorbed at one time, though without such an explanation the answers to individual questions simply add to the confusion.

All persons responsible for advising parents regarding the health of their children, whether expert or not in the field of eye health, will therefore welcome Dr. Scobee's little book. It gives fully and clearly the information that parents of a cross-eyed child want and need, with special attention to the questions that trouble them. The interesting style of the writing carries the reader along; the many simple drawings and diagrams help him to understand the descriptions.

The book is written for parents, but many persons well-informed on child health in general, including physicians who are not specialists in the diseases and surgery of the eye, will find it helpful in clarifying their knowledge of the causes and treatment of squint. It should be familiar to all persons responsible for advising parents and should be available to the parents of every cross-eyed child.

Marian M. Crane, M. D.

FATHER LAND; a study of authoritarianism in the German family, by Bertram Schaffner, M. D. Columbia University Press, New York, 1948. 203 pp. $3.25.

In understanding the process of child-rearing it is often necessary for us to turn to other countries. This book, which makes a study of the German family, and particularly German parents, is an excellent example of the parallel between the family itself and the credos of national life. A student of child-rearing will find in the excellent descriptions of the German father and mother and their indoctrination of the child much evidence to show not only why the Nazis could utilize this bringing-up but how any process of child-rearing fits into a national scheme. It is an excellent transition between the theoretical background of child development and the historical actuality of modern life.

Henry H. Work, M. D.

• CALENDAR

Mar. 20–26—National Boys' Club Week. Information: Boys' Clubs of America, 381 Fourth Avenue, New York, 16, N. Y.

Apr. 2–9—National Negro Health Week. Thirty-sixth observance. Information: National Negro Health Week Committee, Federal Security Agency, Public Health Service, Washington 25, D. C.

Apr. 3–4—Association of Maternal and Child Health and Crippled Children's Directors. Chicago, Ill.

Apr. 7—World Health Day. Sponsored by World Health Organization.

Apr. 9–14—Association for Childhood Education International. Study conference. Asheville, N. C.

Apr. 12–14—United States-Mexico Border Public Health Association. Annual meeting. City of Chihuahua, Chihuahua, Mexico.

Apr. 18–22—American Association for Health, Physical Education, and Recreation (a department of the National Education Association). Annual convention. Dallas, Tex.

Apr. 20–22—Girls Clubs of America. Fifth annual conference. New York, N. Y.

Apr. 23–28—National Conference of Social Work. Seventy-seventh annual meeting. Atlantic City, N. J.

Some other organizations meeting in association with the National Conference of Social Work:

American Association of Group Workers.
American Association of Medical Social Workers.
American Association of Psychiatric Social Workers.
American Association of Social Workers.
Child Welfare League of America.
Committee on Services to Unmarried Parents.
National Association of School Social Workers.
National Association of Training Schools.
National Child Labor Committee. (Public dinner meeting, April 25.)
National Committee on Homemaker Service.
National Council on Social Work Education.
National Florence Crittenton Homes.
National Probation and Parole Association.
National Publicity Council for Health and Welfare Services.

Apr. 24–26—Thirteenth Annual Conference on Conservation of Marriage and the Family. Institute for Research in Social Science, University of North Carolina. Chapel Hill.

Apr. 24–28—National Tuberculosis Association. Forty-sixth annual meeting. Washington, D. C.

Apr. 29–May 6—Boys and Girls Week. Thirtieth annual observance. Information: Boys and Girls Week, 35 East Wacker Drive, Chicago 1, Ill.

May 1–5—American Psychiatric Association. Annual meeting. Detroit, Mich.

May 3—National Board of the Young Women's Christian Association of the United States of America. Annual meeting. New York, N. Y.

May 19—Directing Council of the American International Institute for the Protection of Childhood. Annual meeting. Montevideo, Uruguay.

Illustrations:
Cover, Esther Bubley.
Page 131, Philip Bonn.
Page 132, Wide World photograph.
Page 134, Williamsburg Day Nursery, Brooklyn, N. Y.
Page 135, Play Schools Association, New York City.
Page 137, Columbus (Ohio) Citizen.
Page 138, Hiram Myers.

To Safeguard the Adopted Child

Many States are working to improve their laws and procedures with regard to adoption. And organizations and individuals often ask the Children's Bureau to help them to evaluate their State's law.

They sometimes ask whether any State has a law that might be considered a model for their State to follow. The answer is that no one State adoption law will fit every State's needs. An adoption law does not stand alone; it is part of the State's network of related provisions for child welfare, planned to meet that State's special needs.

But certain principles, developed out of the efforts of various States to safeguard adoption, may well serve as guides in planning or revising a State's adoption law.

The Children's Bureau has developed a number of such principles. And, on the basis of these, the Bureau has prepared suggestions to serve as guides in considering what changes need to be made in a State's adoption law. These suggestions are given in a recent Bureau bulletin, *Essentials of Adoption Law and Procedure* (Pub. 331).

The bulletin first tells the aims of a good adoption law. These aims are, in brief: *To protect the child* from unnecessary separation from natural parents who might give him a good home and loving care if they had help and guidance. *To protect the natural parents* from a hurried, ill-considered decision to give up their child. *To protect adoptive parents* from taking responsibility for a child about whose heredity or capacity for development they know nothing.

These three types of protection may more readily be offered, the bulletin suggests, if adoption is carried out according to specified principles, which may be summarized as follows:

1. Ending the parental rights of the natural father and mother is as important as establishing the new parental ties.
2. Placements for adoption should be made only by an agency authorized to do so by the State department of welfare.
3. Proceedings should be in a court of record that hears children's cases, preferably in the community where the prospective parents live, and where the child is properly before the court.
4. The court should have the benefit of a social study and a recommendation made by the State department of welfare or an agency designated by it.
5. Consent to adoption should be obtained from the natural parents, or, if they have relinquished their rights legally, from the person or agency having the right of consent to adoption.
6. Hearings should be closed to the public, and the records should be kept confidential.
7. Residence of the child in the adoptive home before the adoption petition is heard should be required, preferably for 1 year.
8. If a final adoption decree is not entered, provision should be made for transfer of the child to a suitable home and for his care and guardianship.
9. Safeguards should be provided in laws related to adoption to assure the welfare of the child in matters that arise because of adoption.

Persons concerned about their State's adoption law should be concerned also about the services available to make the safeguards effective, says the bulletin.

Responsibilities placed by the law on the State department of public welfare will accomplish little for the protection of the children unless funds are provided for employing skilled staff. One essential in such protection is adequate financing of public and private agencies providing services for unmarried mothers and their children.

Again, an adoption law cannot be fully effective in protecting children unless the services needed for placing them in foster-family homes and for other forms of child-welfare service are available to all communities and are used.

In recent years a number of State legislatures have passed new adoption laws or improved their existing ones. This action by the States is encouraging to all who are interested in protection of the estimated 50,000 children adopted each year.

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FEDERAL SECURITY AGENCY
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Arthur J. Altmeyer, Commissioner

CHILDREN'S BUREAU
Katharine F. Lenroot, Chief

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the CHILD

PREMATURE BIRTH IS A PUBLIC-HEALTH PROBLEM

ARTHUR J. LESSER, M. D., *Chief, Program Planning Branch, Division of Health Services, Children's Bureau*

U. S. SUPERINTENDENT OF DOCUMENTS
MAY 4 1959

PREMATURITY is our biggest challenge today in saving the lives of babies.

Many thousands of the prematurely born infants who now die each year could be saved to grow up as normal, healthy children.

Thanks to the pioneering work that some doctors and nurses are doing, we are developing much experience in how to give the highly skilled care that premature babies must have because they cannot breathe, swallow, or maintain body temperature as full-term babies can. We are beginning to learn, too, more about preventing premature labor.

The double task ahead of us now is to apply this experience more generally and to increase our knowledge through new research in order to learn new ways of preventing death.

This issue of THE CHILD, which is devoted entirely to the problem of prematurity, is too limited in space to touch on all aspects of the subject. But if the papers published here, which present the observations of some workers who have given special attention to this problem, stimulate a broader interest in this battle for life, they will have served their purpose.

Leona Baumgartner

Leona Baumgartner, M. D.
Associate Chief, Children's Bureau

WE KNOW comparatively little about premature birth as a national problem. We do not know how many babies are born prematurely each year in the United States, because prematurity is measured by birth weight and until recently few States had an item on the birth certificate asking for the baby's birth weight. Our principal sources of information at present on prematurity are the death certificates that give premature birth as the cause of the baby's death, plus a few State, city, and hospital studies.

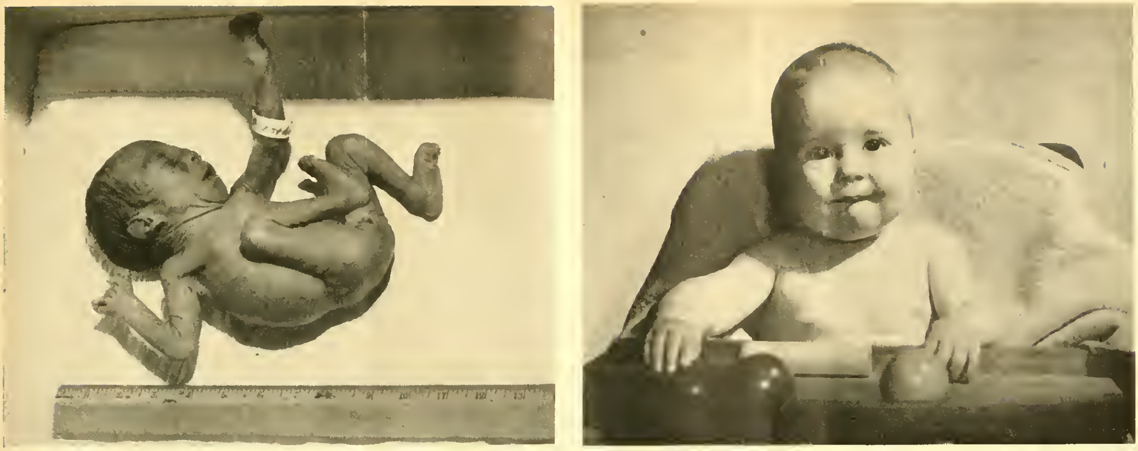
It is obvious that if we are to have comparable reporting on premature birth throughout this country there must be Nation-wide agreement on just what premature birth is. But no agreement on definition has been achieved as yet.

Some years ago the Bureau of the Census, the Children's Bureau, and the American Public Health Association agreed to define premature birth as "the termination of pregnancy in the period from the beginning of the 28th to the end of the 37th week of gestation." But this definition has become generally discarded. There is more widespread acceptance and use, with some reservations, of the definition recommended by the American Academy of Pediatrics: "A premature infant is one who weighs 2,500 grams or less at birth (not at admission) regardless of the period of gestation. All live-born premature infants should be included, evidence of life being heart beating or breathing."

As used, this definition is often modified to read "one who weighs less than 2,500 grams," excluding babies who weigh exactly 2,500. Although weight is accepted as a more objective and more readily measured criterion of prematurity than length of gestation, some hospitals set a minimum weight as well as a maximum in defining a premature. This is because babies weighing less than 1,000 grams rarely survive. One large hospital, in addition to setting a minimum weight, modifies the definition of evidence of life to require breathing, on the ground that heartbeat alone is not sufficient evidence of life. Individual physicians often also try to judge whether an infant is viable, a rather broad term that refers not only to weight and signs of life but to other rather vague general considerations as well.

Such variations in definition will continue to hamper our collection of information regarding prematurity until they are resolved, probably through the work of a nationally accepted committee. Currently, the Children's Bureau defines a prematurely born infant according to the definition of the International Statistical Classification of Diseases, Injuries and Causes of Death: "A premature infant is a live-born infant with a birth weight of 5½ pounds (2,500 grams) or less * * *." If reporting is to be effective it must be simple and objective, eliminating as far as possible any judgmental factors.

In the absence of Nation-wide reporting of prematurity it is not possible to say how many babies are born prematurely each year in the United States.



As the premature baby grows older he should gradually become more and more like a full-term baby. Though small, he should have good color, his muscles should be firm, and he should gradually become active and alert. If he is protected from infection and gets the proper feeding and care he will catch up with the normal full-term baby, as a rule by the time he has reached the age of 4 years.

The figure usually accepted, 5 percent of the live births, is based on several studies, including those made by the New York City Department of Health and the Children's Bureau. Wherever the studies include a large proportion of Negro infants a higher incidence of prematurity is reported, for Negroes are more apt to have a low birth weight than whites.

Incidence of premature birth varies

Enough studies have been made to caution us in the use of the 5-percent figure in planning programs for the care of premature infants, for the factors which affect the incidence of premature birth vary from community to community. The incidence at the Johns Hopkins Hospital during a 20-year period was reported to be 11.7 percent. At the Denver (Colo.) General Hospital, 20 percent of the babies born in the 3-year period beginning July 1, 1946, alive were reported as born prematurely, and at the Colorado General Hospital, during the same period, the incidence was 12 percent.

Now that almost all the States include birth weight on the birth certificate, in a few years it will be possible to have some national and State data on the incidence of premature birth.

The greater a premature baby's birth weight, the better are his chances of surviving. Therefore for any study of premature babies, it is essential to know how their weights are distributed. Table 1 gives this distribution in a group of 12,813 premature births in New York City in 1948.

This table is of interest because it is based on a large number of premature infants. We cannot, however, expect the distribution of weights in a hospital center that is part of a State health department's premature-infant program to be the same as this one. This is because such centers frequently receive a higher proportion of small babies than do hospital nurseries, which draw almost entirely on their own obstetric departments and admit few babies born outside the hospital.

TABLE 1.—Number and percentage of premature infants by birth weight groups, New York City, 1948

	Number	Percent
Total	12, 813	100. 0
Less than 1,000 grams	563	4. 4
1,000–1,499 grams	816	6. 4
1,500–1,999 grams	2, 231	17. 4
2,000–2,499 grams	9, 203	71. 8

For example, in the premature-infant center of the Herbert J. Thomas Memorial Hospital in South Charleston, W. Va., which serves Charleston and Kanawha County, only 7 percent of the 145 prematures admitted in the first year of operation were in the favorable group—2,001 to 2,500 grams—compared with 71.8 percent in the 2,000- to 2,499-gram group in New York City in 1948. Thirty-eight and one-half percent of the prematures at this center weighed 1,500 grams or less, as compared with 10.8 percent for the similar weight group in New York City in 1948. In another small group, of 441 prematures studied in 4 hospital centers of the North Carolina program, 33.3 percent of the infants weighed 1,500 grams or less.

It is true that the number of infants in these two State programs is small, but the fact that the proportion of small babies admitted to these centers was so much higher than the expected incidence has considerable significance in planning programs.

When we look at the factors influencing the incidence of prematurity, we need to emphasize not only specific conditions associated with premature birth, particularly abnormalities of pregnancy, but also inadequate prenatal care. It is undoubtedly significant that about half of the mothers delivered at the Denver General Hospital in 1948 had had no prenatal care, inasmuch as a fifth of these mothers were delivered of infants who weighed less than 2,500 grams at birth. Eastman found that premature birth occurred in 24.9 percent of his patients who had poor prenatal care, or none, as compared with 7.8 percent of those who had good care. The social conditions under which the pregnant woman lives, the stresses and strains in her home situation and their effect on her nutrition, and the availability and utilization of good medical care are unquestionably major factors in the incidence of premature birth.

Of particular interest is the large proportion of premature births—about 60 percent according to a study by Eastman (American Practitioner, March 1947)—to which it was not possible to assign a specific cause. Further study is needed of such births if preventive measures are to make an appreciable reduction in the incidence of prematurity. To quote Eastman: "If this be true, in about 60 percent of all premature births, no specific explanation for the accident can be educed. What can be the cause of the early onset of labor in these cases? In all medicine there is surely no more important problem than this, since it entails a threat to the lives of some 150,000 babies annually in this country alone."

Studies have been made of deaths of premature babies in several hospitals that have special facilities for prematures. Such hospital statistics should not be compared with one another in order to measure quality of care, inasmuch as the hospitals use various definitions of prematurity and serve different segments of the population.

We need a standardized method of studying deaths of premature babies in hospitals. Such standardization will greatly help in getting more accurate statistics on a more uniform basis.

Premature baby born in hospital has better chance

The supplement to the Report of the Academy of Pediatrics on Child Health Services and Pediatric Education contains data on the deaths among premature infants in 323 hospitals, with separate figures for those born within the hospitals and those born elsewhere. Of particular significance is the high percentage of deaths—35.6 percent—among premature infants born elsewhere and admitted to the hospitals, as compared with 21.5 percent among infants born in the hospitals. Recently, several State and local health departments and hospitals having premature-infant centers have made mortality studies. Such a study at the Colorado General Hospital, of 205 infants, revealed that among 104 premature infants born in the hospital, only 9.6 percent died; but among 101 infants born outside and admitted to the hospital 28.7 percent died. The babies born elsewhere and admitted to the hospital showed a heavy concentration in the lower-weight groups. Only 19 percent of them were in the favorable weight groups—2,000 to 2,499 grams weight—as compared with 65 percent of the infants born in the hospital. (Program Review, prepared by Denver Regional Staff, Children's Bureau, March 15, 1950.)

Among 145 premature infants in the Herbert J. Thomas Memorial Hospital, South Charleston, W. Va., 34.5 percent died—a seemingly high fatality rate. However, more than three-fourths of the infants were born outside the hospital and more than one-fourth of them were born at home. We have referred previously to the high proportion of small babies among the West Virginia prematures. When the figures are examined by weight groups, this center has an excellent record for survival of infants.

TABLE 2.—Deaths under 1 month of age among infants born in New York State (exclusive of New York City) by weight at birth, 1946

Birth weight	Total live births	Deaths under 1 month	Rate per 1,000 live births
Total	134, 266	3, 116	23. 2
2,500 grams and over	113, 561	903	8. 0
Less than 2,500 grams	8, 470	1, 666	196. 7
Under 1,500 grams	1, 245	945	759. 0
1,500–1,749 grams	622	201	323. 2
1,750–1,999 grams	989	180	182. 0
2,000–2,249 grams	1, 943	189	97. 3
2,250–2,499 grams	3, 671	151	41. 1
Not stated	12, 235	547	44. 7
Premature gestation	883	341	386. 2
Others	11, 352	206	18. 1

From: "Public Health in New York State: 1946, Vital Statistics" Annual Report of the Office of Vital Statistics for the year 1946, New York State, July 30, 1948.

The fatality rate for 441 premature infants admitted to the North Carolina program was 12.7 percent.

Statistics such as the foregoing ones from premature-baby centers are among the best we have. What is new about some of these data is the inclusion of large proportions of infants born outside and admitted to the center. This is typical of the premature-baby centers that are operating in cooperation with State and local health departments. It introduces a factor present to only a small degree, or not at all, in most previous studies of hospitals, in which as a rule the premature infants were born in the hospital. The numbers of infants in the State programs are still small, since few such centers have been in operation long enough to report on larger numbers.

Information on a State-wide basis will become available when more States are able to match birth and death certificates to study mortality among premature infants. New York State figures are a good example of such data since that State has had birth weight reported on its birth certificates for the past 10 years. The data for 1946 are included in table 2. Note that nearly 10 percent of the certificates gave no birth weight. Note also that the neonatal mortality rate in the most favored group—2,000 to 2,499 grams—was 61 deaths per 1,000 live births, or almost eight times the neonatal mortality rate for infants weighing 2,500 grams or more, indicating that even this group is in need of special attention.

Larger prematures more likely to survive

That weight at birth, which is an expression of the degree of prematurity, is the most important inherent factor in the survival of premature infants is well shown in table 2, and these figures are typical of all such reports. Most of the infants in the lowest-weight group die during the first day of life. The key to this difficult situation is to prevent premature labor insofar as possible, so as to enable the infant to reach a more favorable weight, and to provide delivery care for the mothers that is in keeping with the special problems of these infants.

Race is generally believed to be a factor in mortality from premature birth because Negro infants are apt to weigh less than white infants. Similarly, plurality of births is a factor because infants so born are smaller than the usual single-born infant. It is clear that birth weight is the fundamental factor in the baby's chance to live.

Only recently Taylor (The Mother, October 1948) has presented evidence that complications of pregnancy have a direct effect on mortality among prematures. Studies done at Colorado General Hospital indicate that there is a much higher mortality among premature infants born of mothers who have had complications than among infants of the same weight groups whose mothers have not had such complications. The type of anesthesia used in delivery is also a factor in the survival of premature infants; one hospital found that considerably more premature infants survive when conduction anesthesia is used (such as caudal or saddle-block) than when other anesthesia (such as inhalation of ether or nitrous oxide) is employed.

Place of birth is too little recognized as a most important factor. We have already referred to information from the Colorado and West Virginia programs regarding this. Not only are a larger proportion of the smaller infants referred to the special centers, but infants are often kept at their place of birth for several days and referred to the center when they no longer appear to be doing well.

Of course, people in unfavorable economic circumstances undergo greater health hazards in general than do other people. But when a premature baby is born into a family without good economic resources, the parents will be unable to pay for the special hospital care such a baby needs, and he may go home with the mother from the hospital whether or not he is developed sufficiently to be well taken care of at home. Or, if the mother is delivered at home, the baby may not receive hospital care at all unless a public program is in operation.

Since premature infants are usually discharged when they weigh about 2,500 grams, they are still small and must have good care if the services they have received at the premature-baby center are not to be nullified by poor care after discharge. The health - department staff, particularly the public-health nurse and the medical social consultant each plays an important role.

Although all the factors we have been discussing are important in the survival of premature babies, after birth the major factor, of course, is the quality of the care he is given.

When home conditions are unsatisfactory the medical social consultant may work with other community agencies in securing needed help in improving the situation, or plans for foster-home care may have to be made.

Training of nurses and physicians in the care of premature infants.

Development of hospital standards and licensing, with emphasis on facilities and personnel for proper care of premature infants.

Consultation to hospitals (principally by nursing consultants) to raise the standards of care for full-term as well as premature infants.

Loan of incubators, together with consultation regarding their use.

Provision of transportation of premature infants to premature-infant centers.

Development of designated premature-infant centers and purchase of hospital care for them.

One feature of a comprehensive State or local program for saving the lives of premature babies is safe and rapid transportation of the baby from his place of birth to the hospital.

Now let us ask: What is being done to meet the problem of premature birth?

Though State and local health departments are proceeding in various ways in their efforts to save premature babies, a basic pattern is evident. Since the term "program" is used in various ways by the States, it might be well at this point to list the types of activities related to premature infants that State health departments are carrying out. These important activities are:

Measures designed to prevent prematurity, such as—

Extension of prenatal services, with emphasis on diagnostic services and the importance of adequate nutrition.

Obstetric consultation for complications during pregnancy.

Hospitalization for complicated pregnancy.

Obstetric consultation to improve management of the mother's labor and delivery in cases of premature birth (since most of the premature-infant deaths occur on the first day of life).

(*Continued on page 161*)

WHEN A PREMATURE BABY IS BORN

HENRIETTA MARQUIS, M. D., *Acting Director, Division of Maternal and Child Health, West Virginia State Department of Health, Charleston*

When a premature baby is born, whether at home, in a small hospital without adequate facilities, or in a large hospital that has a standard unit for premature babies, he will need specialized care. Let us concentrate on the elements that should be available to insure this baby's survival.

The premature birth of a baby is a medical emergency. Every midwife and physician should be educated for the emergency and know how and where to obtain help and action. Whenever possible preparations should be made for the baby before he is delivered. Suppose he is born in a rural home and no neighboring hospital has facilities for his care. The State health department, through its division of maternal and child health, should have planned with the county health department so that upon notification to that department a specially trained public-health nurse will be sent to the home as quickly as possible. Equipment for premature infants should also be made available and, if possible, a pediatric consultant. The mother should be carefully instructed about how to care for her baby and about the need for medical and nursing supervision.

If the baby is born in a rural or an inadequately equipped hospital, in an area that has no premature center, the health department can be called upon for the same type of service. Incubators can be lent, pediatric consultants can be used when necessary, and the public-health nurse can investigate the home and instruct the mother before the baby is discharged from the hospital. The baby should not leave the hospital until arrangements for his care at home meet certain standards. After the baby's discharge the public-health nurse should make further visits until the baby is well on the road to survival and can be referred for follow-up to a well-baby conference, if the family has no access to private medical care.

Let us suppose a premature baby is born, either at home or in the hospital, in an area that has a premature-infant nursery. The physician or midwife immediately notifies the proper authorities who arrange for transportation to the center. Many localities have a special ambulance or automobile equipped with a portable incubator that carries a small oxygen tank. In West Virginia our nurse is picked up by the ambulance. While in transit she heats her incubator and then carries it to the baby. She dresses the baby in a packet of sterile clothing that she brings with her. The oxygen is turned on, and the baby is placed in the incubator and carried into the ambulance. The car is driven to the center with its siren sounding.

While in transit our nurse has on hand material to cope with emergencies. When the nurse and baby arrive at the premature center, the baby is transferred from the portable incubator to an incubator that has already been heated and filled with oxygen.

What constitutes a center for premature babies? Space is allotted in the hospital separate from the nursery for the full-term babies. The set-up does not have to be elaborate. One of the best premature nurseries is that under the supervision of Miss Lundeen at the Michael Reese Hospital in Chicago. I remember my amazement as I viewed its simplicity the first time I saw it.

Centers for premature babies base their procedures and practice on four principles formulated to meet the physiologic handicaps with which all premature babies are born: (1) Competent nursing care with the least possible handling; (2) preservation of normal body temperature; (3) prevention of infection; and (4) adequate nutrition.

Dr. Myron E. Wegman has said: "Constant and competent nursing care means loving attention in the truest sense of the word." For each full-term infant, 2 hours of nursing care are required every 24 hours; but 6 hours are the minimum for a premature infant. There should be one nurse for every four babies per shift. The degree of prematurity affects the amount of care needed: The 1,000-gram baby needs more care than the 2,000-gram baby needs. The premature baby must be watched almost constantly during his first 48 hours. It requires more time to feed him; he may need special treatments; and he must be closely watched for cyanosis and other complications.

All these things take extra time, but more than anything else it is important for the nurse in the nursery for premature babies not to cut corners. She must feel sure that she has enough time to carry out each phase of her job meticulously, without skimping on technique or hurrying a feeding. But however much time is available, it cannot replace intelligence and interest. And neither organized plans nor legal requirements can insure good care when these attributes are lacking.

Much work has been done on establishing minimum standards for maternity homes and for nurseries for newborn babies. Those requirements play an important part in the over-all program, but they cannot do the whole job. There may be incubators and suction apparatus; there may be an adequate schedule for nurses; there may be a fine formula room; but none of these will suffice without real interest and drive. For without them it becomes easy to let the incubator run without

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Condensed from a paper read at an institute on the care of premature infants, held at Meharry Medical College School of Nursing.

Besides helping the premature baby to maintain a stable temperature, an incubator regulates the humidity of the atmosphere and helps in administering adequate oxygen concentrations.

checking its operation; to make the nurse's schedule a farce by calling her out of the nursery for so-called emergency duty elsewhere; to negate the fine equipment in the formula room by understaffing the room to the point where speed-up results in taking unsafe chances.

All nurses who work with premature babies should have special preparation. But if that is impossible, we may demand as a reasonable minimum that the nurse in charge of the nursery has had such preparation and has the authority and ability to train those working under her. The existing shortage of nurses has caused many institutions to use untrained personnel such as nurses' aides and ward maids. If these have aptitude and interest and are trained and supervised carefully they can do excellent work.

The second requirement in the care of premature babies is the preservation of normal body temperature. This calls for some apparatus to prevent wide fluctuations in temperature and to help the infant conserve his own body heat. Therefore the incubator. Standards for incubators that will accomplish these ends have been set up. Some of the approved incubators are relatively low-priced. (Safety devices to protect against mechanical failures are essential.) Besides helping the baby to maintain a stable temperature, the incubator regulates the humidity of the atmosphere and helps in administering adequate oxygen concentrations. An incubator can act as an isolation unit and can protect the baby from infection.

Fine incubators, however, cannot take the place of intelligence or interest in nursing care, and by the same token a premature program based on the purchase of an incubator without properly planning for its use is likely to be futile.

Thirdly, whether the baby is at home or in a hospital, he should be completely segregated from everyone except the person caring for him. Admission to the premature room or unit must be limited for doctors as well as anyone else. Usually it is possible, except in institutions caring for only one or two premature infants, to insist upon completely separate nursing personnel. It is far more difficult to have a separate staff of physicians, but this objective should be kept in mind when schedules for staff members are made. It is best to have one pediatrician in charge of the unit, and if that is impracticable, to set up a rotating service of not less than 3 months for each physician.

The use of gowns in premature units is less important from the standpoint of physical coverage than as a reminder to observe scrupulous technique.

Hand-washing facilities must be placed so strategically that the staff is constantly reminded of their use.

Face masks as commonly used have more disadvantages than advantages. Although they may prevent infection effectively part of the time, this advantage is offset when a worker with a cold is tempted to go into the nursery under the mistaken impression that the mask will protect the babies. Touching the mask with the hands or wearing it long will defeat its purpose.

Another useless procedure is the routine nose-and-throat culture for personnel. It gives a false sense of security. Nose-and-throat cultures cannot detect viruses, and at best they can reveal the presence or absence of streptococci or pneumococci only at the time of taking the culture. While the culture is being read, the state of the nose and throat may become completely different. Reliance is much better placed on questioning and inspecting personnel and on permitting no one with any sort of illness to enter the premature unit. This is perhaps the most difficult of all the rules to enforce. Low-salaried workers are loath to lose pay for a day off duty. Better personnel practice is to assign those who have minor colds to duty elsewhere in the hospital. This will encourage the prompt reporting of illness.

The premature baby's laundry must be done separately from other hospital laundry. Each baby should have his own supplies, and everything should be done for him in his own personal unit.

The fourth principle concerns nutrition. Some pediatricians believe that breast milk is the best food for premature babies, although others have evidence that partly skimmed milk with added carbohydrates is the feeding of choice. In Dr. Hess' clinic at the Michael Reese Hospital, breast milk only is used. Dr. Gordon of Denver and Dr. Levine of New York believe that partly skimmed cow's milk gives the best results. Dr. Powers of New Haven also prefers to use this type of milk rather than breast milk. The precise type of food used is important up to a point, but equally important is the preparation of the milk and the attention paid to the baby while he is being fed. It is frequently necessary to feed these babies by gavage. Needless to say, only experienced, well-trained nurses should be permitted to carry out such a procedure.

There is no point in expending energy and funds to save the life of a prematurely born baby only to have him discharged from the hospital to go to a home where his parents cannot look after him properly. About a week after the baby is admitted to the premature center, a report should be sent to the public-health nurse. She visits the baby's home. She wins the confidence of the parents and explains the details involved in the care of the baby. She

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SOME FACETS OF THE COLORADO PREMATURE-INFANT PROGRAM

HARRY H. GORDON, M. D., Department of Pediatrics, University of Colorado Medical School, Denver.

FOR the past 2 years Colorado has had a premature-infant program as a joint responsibility of its State health department and State university. We wish to discuss with you some of our experiences, and to stress that an effective program must have many facets besides good nursery care.

Some years ago, Dr. Roy Cleere, executive director of the Colorado State Health Department, and Mrs. Vesta Bowden, then nursing consultant for its Division of Maternal and Child Health, collected data on neonatal mortality in Colorado. Our rate for deaths due to prematurity was worse than those of the neighboring States of Kansas and Nebraska, better than that of New Mexico. As was to be expected, we, too, had a problem.

Agree on need for premature-baby center

In late 1946, in consultation with representatives of the Children's Bureau, the division of maternal and child health called a conference of representative nurses, social workers, practicing pediatricians, obstetricians, and general practitioners, and members of the faculty of the State university medical school. The practicing physicians agreed on the need for a premature center to which infants requiring special care could be referred. They were concerned lest a program be developed in which transfer of all infants to this center would be compulsory. Reassurance on this point was given, and the State medical society gave approval, with a caution on the dangers of the use of Federal funds. A plan and agreement were drawn up for approval by the State health department and the board of regents of the university, outlining the aims of the program, the division of responsibilities, the methods for payment and for review of progress.

In the discussions which followed, it was agreed by representatives of the State health department, the Children's Bureau, and the university that any premature center which was established at the Colorado General Hospital, the university teaching hospital in Denver, must have as primary aims not only service to patients, but also instruction of personnel. Furthermore, the high cost of care of these infants, the limited funds and personnel, indicated the need for a comprehensive program aimed at prevention or mitigation of the degree of prematurity and at follow-up care which might decrease the duration of initial hospitalization and prevent readmissions. This, in turn, required visiting-nurse, social, and nutrition services, as well as provision of medical and hospital care.

Many professions represented

Since the program called for participation of large numbers of people—medical, nursing, social-service, and nutritionist representation from the divisions of maternal and child health of the health departments of both Colorado and Denver, representatives of the divisions of public-health nursing of Colorado, Denver, and the tri-county area surrounding Denver, members of the faculty of the school of nursing of the University of Colorado, nurses, social workers, obstetricians, and pediatricians from the university hospital—a monthly conference of these representatives was arranged. This is now held under the chairmanship of Dr. John A. Lichty, associate professor of pediatrics and pediatric consultant to the State health department, and permits reports of progress, review of procedures, and airing of grievances. More intimate, personal conferences permit ventilation of more intimate personal misunderstandings. During the past few months the staff of the Denver Regional Office of the Children's Bureau have reviewed the charts of 205 admissions to the premature center for the year beginning July 1, 1948. We hope to obtain from their final report much advice concerning improvements; they have been kind enough to furnish us some preliminary data which will be cited later.

Incidence of premature birth high

It has been known for many years that the mortality rates in prematurely born infants vary inversely with their birth weights, i. e., the more mature the baby, the greater his chance of survival. Dr. E. Stewart Taylor, our professor of obstetrics and gynecology, reviewed the incidence of premature births at the Colorado and Denver General Hospitals, two services for which the university is responsible. He found that infants weighing less than 2,500 grams comprised approximately 20 percent of all live births at the Denver General Hospital, a hospital for the indigent of Denver, and 12 percent at the Colorado General Hospital, a hospital for the indigent of the State, as compared with the 5 percent to 7 percent reported by Dr. Baumgartner for New York City, and Dr. Bain for numerous hospitals throughout the country. Furthermore, some 40 percent to 60 percent of the mothers delivered in the Denver Gen-

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An address given before the Association of State and Territorial Health Officers, at Washington, D. C.

eral Hospital had had no antenatal care. These results were reported to Dr. Ruth Raatama, Director of Maternal and Child Health for Denver, and she is trying to develop a program for decentralized antenatal clinics in the city and county of Denver.

The Colorado State Health Department is already compiling data on incidence of premature births from the new certificates, which include birth weights. From these one will be able to determine the areas in Colorado in greatest need of help. And what is needed? Not only a premature center, but strong local public-health units. The nutritionist helping the mother to obtain an adequate diet during her pregnancy; the social worker, helping to obtain hospitalization or housekeeping aid where the pregnancy is complicated; the visiting nurse finding the pregnant woman who is getting no antenatal care, and giving her help not only as a nurse, but also as a nutritionist, social worker, and physician, in areas where such professional help is not available; and the general practitioner, backed up by an obstetrical consultant when needed, all may help in keeping smaller infants in utero until they are closer to term.

For good management of premature labor

The majority of deaths of prematurely born infants occur on the first day of life. This again is not so much a problem of highly specialized nursery after-care, but rather of delivery-room procedures. We have distributed to all the doctors of Colorado a set of simple instructions, prepared by Dr. Taylor, for the management of premature labor. Our problem is one of professional instruction, and of trying to assure that personnel and facilities for resuscitation will be available at premature labors. Our State health department should be able, shortly after the close of the year, to match birth certificates with death certificates and call to the attention of individual hospital administrators and medical boards, their performances in comparison with the obstetric divisions of other hospitals. Local pride should serve as a resource for decreasing mortality. The mortality rate for 288 infants weighing less than 2.5 kilograms at birth in the Colorado General Hospital during a period of 3 years beginning July 1, 1946, was 12.9 percent. For 273 infants whose birth weight was between 1.0 and 2.5 kilograms, the mortality rate was 8.8 percent.

I will not go into the details of nursery care. Suffice it to say that if nurseries for full-term infants were of higher quality, most prematurely born infants who weigh between 2,000 and 2,500 grams could be given care at the place of birth. The American Academy of Pediatrics has finished its survey of facilities for pediatric care, and there is now available in each State data compiled by the physicians themselves which can serve as a basis for improvement of this care. At least in new hospitals one has a right to expect modern nursery facilities for all newborn infants.

This would then leave only a relatively small number of infants who would require transportation to a special premature center—most of the 30 percent of prematurely born infants who weigh less than 2,000 grams, and that portion of the 70 percent who weigh more than 2,000 grams who are having difficulties. A recent analysis by Dr. Taylor of the effect of complications of pregnancy or labor on the mortality rate in prematurely born infants indicates that in every weight group there is a significantly greater mortality for infants born from abnormal pregnancies or deliveries. For a group of 477 infants born at Colorado and Denver General Hospitals weighing less than 2,500 grams, the mortality rate was 8 percent for the "normals" and 37 percent for the "abnormals." It has therefore become our practice to consider prompt transfer to the premature center of all infants born prematurely at Denver General Hospital to mothers whose pregnancy or delivery has been abnormal.

The problem of transportation requires that oxygen be available during the period of transport. The Colorado premature center sends an ambulance, a pediatric resident, and an incubator to any place within 35 miles of Denver to pick up babies. The problem of transportation to the 35-mile mark is the responsibility of the referring physician. The Colorado State Health Department has provided incubators, either for care or transportation, at 18 sites.

Since we have only 20 beds in our premature nurseries, you may be interested in the criteria for admission. Infants born in the Colorado General Hospital who weigh between 2,000 and 2,500 grams are admitted to the full-term nurseries rather than to the premature nursery unless they are doing badly. Infants born outside our hospital, weighing less than 2,500 grams, are admitted if in the judgment of the referring physician or public - health nurse, facilities for care at the place of birth are inadequate. There is no

Expert nursing care is only one of the many expensive services that a premature baby needs.

means test, and the Colorado General Hospital submits its bill for care at a fixed per diem of approximately half the hospital per diem directly to the State health department. The State health department may, on the basis of social data, submit a statement of costs to the parents with an offer to accept part or whole payment.

The absence of the means test in the agreement between the health department and the university led to much suspicion by the State medical society. This was only partly mollified by the fact that referrals were put completely in the hands of private physicians, unless the patient had been referred by a public agency. At the end of our first year of operation, a complaint was made to the public-policy committee of the State society that we were interfering with private practice. We submitted data indicating that 174 of our first 175 patients were medically indigent. The one exception was an infant whose birth would have prevented his pediatrician from taking a vacation because of his personal social obligations to the parents. The complaints were thrown out by the public-policy committee, and we have had no further open difficulties. The analysis of the data showed that the private physicians and private hospitals were taking care of many medically indigent people. Young couples who can afford through savings or Blue Cross to arrange for a full-term delivery find themselves wholly unable to pay for the care of a prematurely born infant who may require prolonged hospitalization not covered by Blue Cross. Attempts should be made to have Blue Cross grant coverage everywhere for prematurely born infants.

The Children's Bureau has permitted me to use some of the figures obtained from its analysis of our admissions for the year beginning July 1, 1948.

Average days and computed cost of hospitalization of 165 infants discharged alive from University of Colorado Premature Center, year beginning July 1, 1948

Birth-weight group (kgm.)	Number of infants	Hospitalization cost [1]		
		Days average	Average all infants	Highest 25 percent
1.0	2	68	$1,020	-------
1.0–1.5	29	55	827	More than $1,000
1.5–2.0	53	38	572	660
2.0–2.5	81	13	199	330

[1] Computed at arbitrary per diem of $15, exclusive of medical services.

The average costs of hospitalization were estimated as varying from an average of $199 for a large infant to $1,020 for a small one. For 25 percent of the infants in the three largest-weight groups, the estimates of cost ranged from more than $330 to more than $1,000. Since the per diem was calculated on a modest basis, and excludes medical services, it becomes quite obvious that the debt into which parents may be thrown by a premature birth may constitute one of the greatest handicaps of prematurity.

This baby has been discharged from a premature-baby center in good condition, and a public-health nurse, who, like the nurses at the center, has had special training in methods of caring for such babies, is helping the mother to give the baby the kind of care he needs.

Medical social worker helps families

Needless to say, service by a medical social worker has been of the greatest value to the families of our patients. During the year surveyed 86 percent of the families received an initial exploration of circumstances by either the hospital social worker or the medical social consultant of the Colorado State Health Department to determine whether social and emotional problems existed which would affect the infant's care. Forty-six percent of the families received continued case work either by the hospital social worker, the health-department social-service consultant, or other agencies. We won't stop for details of case histories—in many instances we believe that the social case work meant more to the whole family unit than what had been done for the premature infant whose birth called our attention to the family.

We come now to the problems of follow-up care, and here the public-health nurse again plays a most important role. On admission of every infant to the center, the division of nursing service of the State health department is notified. If the source of original referral is a private physician, the public-health nurse from the local health unit asks the physician to find out from the mother whether she wishes assistance from the nurse in planning for care of the infant. For the year surveyed, on the basis of incomplete returns of referral slips to the hospital, home visits were made in 67 percent of families. The visits of the public-health nurses have been of great help in preparing the home for the premature infant, and in diminishing the mother's anxiety about her ability to care for the infant.

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PREMATURITY IN RELATION TO OBSTETRIC CARE

A. L. CARSON, JR., M. D., *Director, Bureau of Maternal and Child Health, Virginia State Department of Health, Richmond*

Good medical supervision throughout pregnancy is a step toward preventing premature labor.

THE CARE of premature infants involves highly specialized pediatric procedures. Emphasis on these techniques is to be expected when programs to reduce mortality from prematurity are developed. It is possible that the pediatric aspects may receive such prominence that plans for these programs may be made without sufficient consideration being given to the relationship of prematurity to obstetric care.

How often has this remark been made by someone in a premature station: "If they could only give us better specimens to work with." This may be interpreted as a complaint but more often it is a lament. Is the type of obstetric care to be considered a factor in prematurity?

Some conditions related to prematurity encountered during the prenatal period cannot be prevented by obstetric care, or may be influenced but slightly by such care. Among these are spontaneous rupture of the membranes, twin pregnancy, premature separation of the placenta, certain types of toxemias, habitual premature labor, and other nonpreventable situations, such as enforced abdominal operative procedures.

Other conditions involving prematurity may be influenced by obstetric care. Some of these about which something may be done are:

1. ***Placenta praevia.***—Earlier diagnosis and observation of these cases in the hospital over a longer waiting period, plus the wide distribution of blood banks, make possible, in many instances, a reduction in the degree of prematurity.

2. ***Nutrition.***—Many mass studies have been made of the outcome of pregnancy in relation to diet in women. The People's League of Health of England investigated the effect of nutrition in 5,022 pregnant women. Half of these had supplementary minerals and vitamins with a resultant reduction in the incidence of toxemia and premature births. If a good diet is a safety factor to the mother and prevents any one form of toxemia, that alone is important, since toxemia is one of the major causes of premature births.

In the Toronto Studies of Ebbs, Tisdale, and Scott the incidence of premature births in women with poor diets was found to be 8.0 percent. Among women whose diets were equally poor, but who were supplied with supplementary rations of milk, cheese, oranges, tomatoes, wheat germ, and vitamin D, the incidence of premature birth was

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An address given before the Association of State and Territorial Health Officers, at Washington, D. C.

2.2 percent. Burke and associates made a nutrition study of 216 pregnant women from the prenatal clinics of the Boston Lying-In-Hospital. They reported, among other findings, that all the premature babies and all the functionally immature infants of this group were born of mothers whose diets were inadequate. They demonstrated also that the length of the fetus at delivery had a definite relationship to the adequacy of the protein intake of the mother during the prenatal period.

3. Prenatal care.—There is an intangible factor associated with adequate prenatal care that contributes toward the well-being of these pregnant women in that they go to term more consistently than those who have poor or no prenatal care. Again the reasons assigned are many. Among these may be instruction, dietary direction, and early detection of complications, always with due credit to the patient who seeks prenatal care regularly. Anderson and others, in a review of 2,514 cases, found that those patients who had inadequate prenatal care were delivered prematurely more often than those who had adequate care. Prenatal care affords an opportunity for early recognition of conditions for which effective treatment may be instituted. Whether the cause of the disease is known does not matter so much if its treatment is effective. It is known that bed rest and sedation may be a help for the hypertensive; salt restriction for the case having edema, and iron or transfusion for the patient in whom it is justified.

4. Antisyphilitic treatment.—Premature delivery in syphilitic patients may be reduced by treatment. In a few of these cases, pregnancy may terminate prematurely during the time of treatment. This may be coincidental. With the present penicillin therapy it is not felt that the treatment is a factor in producing labor. As time goes on there should be a continued reduction in premature births in women with syphilis.

5. Obstetric skill.—Obstetric skill in handling premature deliveries probably has an effect in preventing intracranial hemorrhage. The delivery of a premature infant by the use of forceps, with an episiotomy, may be preferable to a longer labor against a resistant perineum. Advances in the use of analgesia, anaesthesia, and in the methods of delivery may contribute toward giving prematures a still better chance of survival.

6. Pediatric help.—There are times when the histories of patients are misleading and the estimation of the size of babies is difficult, but not infrequently an operative or spontaneous delivery of a premature infant is anticipated. When this is true, the pediatrician may be requested to stand by, for a few minutes of his help at this time may save the baby.

Attempts to do something about the prematurity problem in Virginia are being made in association with the obstetric-care program of the State health department. The development of plans directed to the improvement of the care of premature infants was delayed, deliberately, for several years until a program of maternity care was established. This program began with postgraduate institutes in obstetrics for physicians. This was followed by the establishment of prenatal clinics, which led into a method of hospitalizing medically indigent obstetric patients with pathologic conditions. These fundamental obstetric-care activities had a definite bearing on prematurity.

The health-department prenatal clinics, conducted in health centers by local physicians, each year render service to one-tenth of the mothers of the State having babies. This service gives physicians an opportunity to emphasize measures to prevent prematurity. Complications may be discovered and difficulties at time of delivery anticipated. A hospitalization plan gives help that is necessary to meet these situations.

The continued operation of prenatal clinics focused attention, some years ago, upon the urgent need of a method to hospitalize those pregnant women for whom such care was considered imperative. An experimental plan was put into effect in one rural county in 1941 using matched State and Federal funds. Under this plan, hospitalization was made available to medically indigent mothers and babies, referred from official maternal and child-health clinics because of complications. Provision was made later to include the same type of nonclinic patient, referred, as an emergency, through the county health department by the family physician. Premature infants were given priority in the group of eligibles. Midwife cases requiring hospitalization were screened through the clinics with the approval of the physician in charge.

The experimental plan proved sufficiently successful to justify expansion. For some time, all the State has been included, except the larger cities with independent health departments. Fifty-one participating hospitals are situated geographically so that every section of the State is within reasonable distance of at least one of them. The hospitals are paid by the State health department on the reimbursable per-diem cost basis. No payment is provided for physicians. This plan, like all other maternal and child-health programs in Virginia, represents the combined planning of the health department and medical and allied professions.

This organized plan of hospitalization is believed to be favorably influencing maternal and infant mortality. In addition to providing for prenatal, delivery, and postpartum complications, emphasis is placed on the care of premature infants. An infant born prematurely as a result of a complication of pregnancy has a much better chance of survival if the condition is discovered early, prematurity anticipated, and hospital delivery arranged. Among the many prenatal conditions accepted as a reason for hospitalization under this plan are toxemia, hemorrhage, disproportion, and similar well-defined evidences of pathology. Premature labor without apparent cause is included also as a reason for hospitalization, mainly to give the resulting premature infant a better chance. When twins are diagnosed, authorization for hospital delivery is approved, not only because of the increased incidence of postpartum hemorrhage but also of the possibility of the resulting premature or immature babies having a better chance of survival.

Care of the premature infants under this plan is of value, but of greater importance is the far-reaching effect the program is having in stimulating improvement of premature care in general.

It is probable that increasing attention will be given to the development of programs to reduce mortality from prematurity. Obstetric care, often of importance in its preventive aspects, must be a real part of these programs.

MEDICAL SOCIAL WORK AND THE PREMATURE BABY

RUTH C. COHIG, *Medical Social Consultant, Social Service Section, Colorado Department of Public Health, Denver*

HELEN A. MASON, *Medical Social Consultant, Social Service Section, Colorado Department of Public Health, Denver. Formerly on the social-service staff of the Colorado General Hospital, Denver*

"I DON'T NEED any help," was the almost defensive comment of the mother of premature twins to the medical social worker who had stopped to see her on the hospital ward. However, as the interview progressed it became apparent that the mother was worried and wished to talk with the social worker. The mother was overwhelmed at the thought of caring properly for two tiny babies, and birth of the twins meant four children in the family under 5 years of age. She was afraid of what the extra responsibility in the home might do to the already strained relations between her and her husband. She doubted her ability to meet additional problems. She wondered if she would have a break-down.

The mother soon realized that she did need help and wanted it, and plans were made for the social worker to visit in the home to assist her. Consultation with a psychiatrist was arranged by the hospital physician because of the mother's concern about herself. Psychiatric treatment was not recommended but the psychiatrist suggested continued social case-work service.

This mother was seen regularly for several months by the medical social worker who helped her gain a measure of personal security. become less anxious about the twins, and work out some of her other difficulties. The mother thought that transportation of the babies to the hospital clinic for medical supervision was an insurmountable obstacle. However, the transportation services of a volunteer agency were obtained so that the babies could be examined regularly. The family situation was discussed with the public-health nurse who was giving nursing supervision in the care of the babies in the home.

The premature birth of a baby may cause a mother unusual anxiety. In the hospital she sees other mothers with their babies but she cannot see or hold hers. She may question whether her child is perfectly formed or be afraid that she has brought about the prematurity. She may be distressed because she will have to go home without him. She may wonder whether she will know how to care for such a tiny baby. She may be worrying about the cost of the baby's stay in the hospital after she leaves.

Medical social workers taking part in the specialized program for premature babies at the Colorado General Hospital have met these and other problems in the families of babies hospitalized at the center. These are difficulties that might hold back the progress of the baby at home in spite of good medical and nursing supervision. Such problems have been inadequate housing, irregular employment, and insufficient income. Marital difficulties, illegitimacy, health problems in the family (both mental and physical), and parental attitudes toward the baby have also been factors which influenced the type of care the infant received.

Medical social service is an integral part of this center's premature-infant program. The medical social workers help to evaluate whether there are social or emotional problems and give social case-work services when these are needed. The worker attempts to learn something of the mother's feeling toward the baby, family relationships, and the home situation. The policy of admitting infants to the hospital without respect to economic status is explained because this is frequently a source of worry, particularly in relation to the tiny babies who have to remain in the hospital several weeks or months. However, those parents who can afford it are encouraged to make voluntary payments for the service.

The information the medical social worker gathers in talking with the parents or in visiting the home is discussed with the doctors, nurses, and technical members of the staff and is also put into the medical record for their use. The information is especially useful to the doctors in deciding the length of the baby's stay in the hospital. They can decide the time of discharge for each baby on an individual basis, knowing the family and home conditions to which he is going, instead of keeping all babies in the center until they reach a certain weight. If it is possible, no baby is discharged from the hospital without the recommendation of the social worker and the public-health nurse or the one who has visited the home and knows the condition there.

From the start of the program, casework service from a medical social worker has been made available to the parents of all premature infants cared for in the center. This includes service to the mother while she is in the hospital.

A medical social worker on the staff of the hospital gives service to the families living within the city and county of Denver. The medical social consultant on the staff of the Colorado State Department of Public Health serves families who live outside the Denver area.

Most of the babies not born in Colorado General Hospital but brought to the center are referred by a private physician. The services of the medical social worker and the public-health nurse are explained to this physician before they are offered to the family. Very few physicians or families have raised any questions regarding social services, perhaps because there has been such obvious need in the families of the infants who were referred to the center.

The medical social worker works closely with the doctors and nurses in the hospital well-baby clinic to which premature babies are brought. The babies discharged from the center are supervised here if they are not under the care of a private physician. The worker exchanges information with the doctors and nurses about the progress of the babies. Frequently the pediatrician consults the worker when a baby fails to make the progress the clinic had expected to see, or when he loses weight. The doctor asks the social worker if anything in the home conditions could account for the set-back and, if so, what can be done to help. She usually makes a home visit and discusses the situation with the pediatrician before the baby's next visit to the clinic.

A baby born at home, weighing 3 pounds and 13 ounces, was admitted to the center shortly after birth. She was the fifth child in a Spanish-American family that had been living on a marginal income for some years. The father was unemployed when the baby was born. He had just applied to the department of public welfare for help. The public welfare worker assigned to the family and the medical social worker discussed the family situation. The medical social worker had found that the assets in the home were strong family ties, good relations between all members of the family, and a genuine concern for the tiny new baby; the only liabilities were the lack of funds and the crowded conditions of the run-down place in which the family had to live. It was quite apparent that the mother would give the baby as good care as the home surroundings and family circumstances would permit her to give.

Because the family was to receive public assistance, the medical social worker's part was to interpret to the public welfare worker some of the problems in relation to the prematurity, and to talk over the situation with the public-health nurse who was to give nursing supervision at home. Meanwhile, the mother was to take the baby to the special well-baby clinic for follow-up care.

A while later, after a clinic pediatrician had seen the baby, he conferred with the medical social worker. The baby was not getting along satisfactorily, he reported. The medical social worker found that the family was no longer receiving assistance because the father had returned to work, but his earnings were hardly enough even to feed the family.

The medical social worker talked with the father with the help of an interpreter. The father told the worker that he was worried about his health. He feared that he would not be able to work much longer to support his wife and children. The public welfare worker and the medical social worker arranged for a physical examination that revealed the father's acute need for medical attention. While he was receiving medical treatment the public welfare department gave financial help to the family, with knowledge that the family had a baby requiring special care from her mother because she was not making the progress anticipated.

This tiny girl progressed slowly. For that reason she was followed longer than 6 months, the usual time at the clinic, and a little over a year after her birth the pediatrician described her as a well baby. She was small, to be sure, but she was developing normally and was well-nourished. The doctor reported that there were no longer any physical problems, and it was agreed that the mother should now take the baby to the child-health conference in her neighborhood.

One of the services of the medical social consultant on the staff of the Colorado State Department of Public Health is to discuss with consultants in other programs of the department, as well as with local health and welfare agencies, the social and emotional problems related to the premature birth of a baby. These discussions have been useful in integrating the available services and in pointing out gaps in community resources for meeting the needs of these babies. Planning for a baby we might call Bobby brought out the need for developing further services for preschool blind children.

Bobby weighed only 1 pound 14 ounces when he was born at Colorado General Hospital. His mother was very attentive during the 5 months of his hospitalization at the center, but the father showed little interest in him. At first the mother was only able to bring out to the medical social consultant her concern over inadequate housing and financial problems. As she gained confidence in the consultant she was able to discuss her serious marital problems and her anxiety over her own insecurity with her family group.

The parents found it difficult to manage the care of four children and the marital tensions increased. The father started to drink heavily and the mother felt that she would have to seek employment to support the children. It seemed that the problems of this family were beyond the function of the medical social consultant of the health department and required intensive and continuing case-work service such as is offered through a family-welfare service. This community resource was interpreted and discussed with the mother. Through the continued case-work services of the medical social consultant, the family was able to make application to a suitable community agency.

Later the parents became concerned over the baby's inability to see and discussed this problem with the medical social consultant. Arrangements were made for full reexamination of the infant's eyes at Colorado General Hospital. A diagnosis of bilateral retrolental fibroplasia was made. The father expressed open hostility regarding the child's blindness and his attitude toward his wife indicated that he felt it was her fault. The father's reaction to the patient's eye condition intensified the marital difficulties and the parents separated.

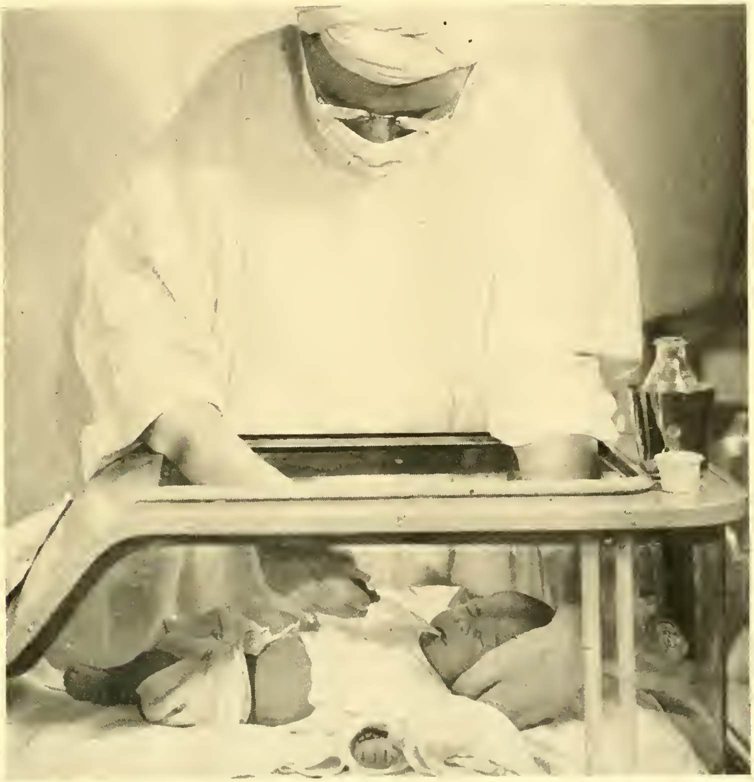
Through the community agency, plans were made for temporary placement of the patient and his brothers in foster homes until adequate future plans could be worked out. Continued medical social interpretation of the patient and his need were made to this cooperating agency. Tentative plans are being made by the Colorado premature-infant-center staff to work with community agencies in developing services for such blind children of preschool age.

The medical social workers take part in certain aspects of the teaching program in the center for premature babies, in addition to the direct social case-work service and the consultant service that they give. They have taken part in the special courses for nurses and physicians by presenting case material as a means of bringing out the social, emo-

(Continued on page 163)

TO IMPROVE THE NURSING CARE OF THE PREMATURE BABY

MARGARET LOSTY, R. N., *Nursing Consultant, Maternity and Newborn Services, New York City Department of Health*



This premature baby is being fed by a nurse who has been specially trained in caring for such babies. Because he is too weak to suck, the nurse feeds him with a medicine dropper.

A PREMATURE baby's life may depend on whether or not the person who takes care of him has the knowledge and skill needed for the care of such infants. Unfortunately, there are not as yet enough professional workers with this special knowledge, and undoubtedly many premature babies die who might have been saved by better care.

New York City recently gathered some evidence pointing to this conclusion, when the maternal and newborn division of the city department of health joined with the Kings County Medical Society in inquiring into the preparation of nurses who had cared for the 55 premature infants who had died during a specified month. Of the 135 nurses who had cared for these 55 babies, only 1 had had any training in the care of prematures.

Seventy-seven of the one hundred and thirty-five nurses were graduate nurses (and it was one of these who did have the special training). Twenty-five were licensed practical nurses; 16 were nonlicensed practical nurses; 8 were student nurses; 1 was a hospital attendant; 3 were student practical nurses; and the status of 5 nurses was unknown.

An address given before the Association of State and Territorial Health Officers, at Washington, D. C.

The impression that there are not enough nurses with special preparation in the care of premature babies is strengthened by observations made in the hospitals of New York City by the city health department's hospital consultation service, whose purpose is to improve the hospital care given to mothers and newborn infants, including prematures. This service sends survey teams to the various hospitals to observe the quality of care and make recommendations for improving it. Each team includes an obstetrician, a pediatrician, and a public-health nursing consultant.

These teams report that too many premature babies are improperly cared for because the members of the hospital staff simply do not know what should be done. Many of the nurses, incidentally, have told the survey teams that they realized how inadequate their training in the care of prematures had been, and that they would like to receive better preparation.

And, according to the pediatric members of the survey teams, it is not only the nurses who need further instruction in the care of premature babies, but also the doctors.

An ideal plan would seem to be for the nurse and the pediatrician who are responsible for the care of the premature babies in a hospital to be taught jointly, along with the public-health nurse who visits the babies in their homes and helps the mothers to care for their babies.

Joint training of this kind is now being given at the New York Hospital. Another hospital in New York City that offers preparation in the care of the newborn, including premature babies, is the Sloane Hospital for Women. This is a 4 weeks' work experience, but it is for nurses only.

It is well recognized that there is great value in learning about different programs. Therefore, many nurses from New York City go for training to hospitals and schools of nursing in various cities that offer special work with premature babies.

Courses in nursing care of premature babies are given in the following schools of nursing: University of Colorado, Denver; Louisiana State University School of Medicine, Division of Nursing Education, New Orleans, La.; and Los Angeles County General Hospital School of Nursing, Los Angeles, Calif.

Some hospitals that offer periods of supervised experience (not courses) in nursing care for premature infants are Margaret Hague Maternity Hospital, Jersey City, N. J.; Michael Reese Hospital, Chicago; Presbyterian Hospital, New York City; and the Johns Hopkins Hospital, Baltimore, Md.

In all these institutions opportunities for clinical instruction and experience in the care of the premature baby are open to both institutional and public-health nurses.

Here is a typical report by a nurse who had the opportunity to receive preparation in a hospital that gives good care to premature babies:

"Before I went for additional training, I had only the vaguest knowledge of how to care for a premature baby, for I had had only 2 weeks' experience in this field during my student days. I was actually afraid to handle such a baby. But at X hospital my whole attitude changed. I was amazed at the attention the nurses gave the babies at feeding time. At the hospital I came from, the nurse would prop up the baby's bottle and leave him to feed himself—even a premature baby! But in X hospital the nurse would sit in a chair and hold the baby while feeding him. She was not in a hurry; she cuddled the baby and talked to him (this was a large premature baby) and in the meantime she had a wonderful opportunity to observe him and see how he was reacting to feeding."

Another nurse's report:

"At Y Hospital I had an opportunity to observe the birth of a premature baby. I learned how to admit a baby to the premature-baby nursery and how to care for him there. I observed the procedure in the well-baby clinic for prematures. The head nurse's lectures and demonstrations were clear and useful. The doctors were cooperative and were always willing to answer our questions. The library was open to us during our free time. After I gained some experience in caring for premature babies I began to regard them in a new light."

One of the important gains that nurses have reported after experience in a hospital that gives especially good care to premature babies is a keener appreciation of the parent-child relationship and of the social and psychological problems involved in the care of a premature baby.

On the whole, we have found in New York City that providing opportunities for periods of instruction and experience in the care of premature babies for the hospital staff, and in-service educational programs, has been an important step toward saving the babies' lives.

When a premature baby is mature enough to be cared for outside of an incubator, the high-quality nurse holds him in her arms while she is giving him his bottle. She cuddles him and talks to him. And she has an opportunity to observe him and see how he reacts to feeding.

LESSER

(Continued from page 149)

Publicity and general educational activities.

Most State health departments are carrying on one or more such activities. Some have programs which include virtually all of them.

A premature-baby program, to be comprehensive—

Should use first-rate facilities, staffed with well-trained personnel.

Should provide consultation services to hospitals.

Should include measures designed to prevent prematurity.

Should provide for the transportation of premature babies to the hospital.

Should be responsible for paying for hospitalization of premature infants.

Should take cognizance of the important role of the general practitioner and the obstetrician as well as the pediatrician in the program.

Should plan with the family for the infant's discharge from the hospital and follow-up.

Full-term infants also benefit

Such a program not only works to save premature babies, but plays an important part in improving hospital nursery care for full-term infants throughout the State as well, since its influence has been found to extend beyond the special facilities for premature infants.

Measures to prevent premature labor and to provide expert care during labor when pregnancy is complicated are taking on an increased importance in these programs. The obstetric consultation clinics in Maryland and Colorado and the hospitalization of patients with complications of pregnancy in Maryland and Virginia are examples of such measures. At the same time it is recognized that there are still many women being delivered with inadequate prenatal care, and that provision must be made for good care through the extension of prenatal clinics.

A few studies of the costs of care of premature infants are becoming available. All show that such care is expensive.

The major item of expense is of course hospitalization, and since hospital care is purchased by State health departments on a cost basis, the average cost will depend on the average daily cost rate per patient of the hospitals used in the program.

In the West Virginia program the average cost of care for 145 infants was $341.70 per infant.

In the North Carolina program the average cost of care for 441 infants was $411.48.

Such cost figures, though they help in planning the over-all budget for a program, do not reflect the wide range in costs for care of infants in different weight groups and do not give an adequate picture of the expenses faced by a family having a premature infant.

For example, in Colorado, there were 29 survivals among babies in the weight group 1,000 to 1,499 grams. The average cost of care for this group was $827 per infant, but for 25 percent of the infants in the group the cost exceeded $1,000. In the weight group 1,500 to 1,999 grams there were 53 infants. The average cost per infant was $572.

For 81 infants weighing 2,000 to 2,499 grams, the average cost per infant was $199.

About 50 percent of the Colorado infants required hospitalization costing $400 or more each and of the families whose incomes were known 83 percent had less than $400 per month. Social data on the first 175 patients in the Colorado program were submitted to a committee of the State medical society, which agreed that 174 of these families could not pay.

The West Virginia program includes on its application form items on family income and on number of dependents. After a review of the first year's operations, the maternal and child-health director stated that if the health department had assumed a fee-collecting role it would have been able to collect from only three families, and then no more than $500. The expenditures for care during this period by the State health department amounted to about $50,000.

Premature babies create family problems

As may be expected with an unanticipated event such as the birth of a premature infant, difficulties in family adjustments to meet the situation are frequent and often serious. Although the most common problems in the Colorado program were found to be inadequate finances and unsatisfactory housing, there were numerous other problems, such as maternal overanxiety, maternal rejection, neglect of other children, and family tensions. There were 38 unmarried mothers in the group. During a year the Colorado program provided some medical social services to 88 percent of the families, and 46 percent received continued case work after the baby was discharged from the hospital.

The studies of the State academies of pediatrics are providing a strong stimulus to the development of services for premature infants, since so many of them are recommending that health departments emphasize such services. Thirty-three State health departments reported to the Children's Bureau that they will develop or expand programs for premature infants if additional funds become available.

Regional centers would help

The development of Nation-wide services for the care of premature infants would be accelerated by the establishment of several well-developed State premature-infant centers which could be used not only for service but also as regional training centers for hospital and health-department staffs, and for consultation to hospitals, to assist them in improving their full-term nursery practices as well as in developing special facilities for premature infants.

In addition to funds for such regional training centers, financial assistance is needed by State health departments to develop premature-infant programs.

It is evident that we need information on premature babies that is not usually obtained in basic research in physiology, anatomy, and pathology. Research could well be directed toward increasing our information regarding the best definition of premature infant, the incidence and distribution of premature birth, the causes of premature birth, the prevention of premature labor, nursery design, methods of care, influence of social and economic conditions on premature birth and on survival of premature infants, and costs of care. When we have learned much more about all these, we should be able to do a better job of saving premature babies.

MARQUIS

(*Continued from page 151*)

may ask the family to make changes in home arrangements to make good care possible. She carefully examines all the brothers and sisters for contagious infection. She may call upon a social agency to help the family solve its problems. Finally, she makes a report to the hospital. No baby should be discharged from the hospital or the center until home conditions are satisfactory for his survival. The nurse makes another visit to the home just before the baby is discharged and reports to the hospital.

In West Virginia we have occasionally had to find foster homes for some of our babies (in collaboration with the department of public assistance). This part of the program is just as important as any other, and the public-health nurse should be instructed so that she appreciates her responsibility for assessing home conditions.

The nurse should return for a follow-up visit within 24 hours after the baby is discharged from the hospital, and she should continue these visits until both she and the mother consider them no longer necessary. It is wise for the baby to have a medical check-up 2 weeks after his discharge from the hospital, and at regular intervals thereafter. If no private medical care is available, the baby should be taken to a well-child conference.

The question is frequently raised whether premature babies are worth saving. The famous men of history who were prematurely born contributed greatly to our civilization. Sir Isaac Newton was an unusually small premature baby, but he grew in strength as he grew older and lived to be 85 years old. Charles Darwin was also extremely small at birth. He grew up to be a member of a 6-year geological survey, survived the hardships of a shipwreck while on a scientific expedition, and was one of the few members of the expedition able to hunt for food to keep them all alive. He lived to be 73. Napoleon was born prematurely, yet lived to be 51. Voltaire, the famous French writer, lived to be 84. Jean Jacques Rousseau and Victor Hugo are other famous Frenchmen born prematurely. A well-controlled study covering a 5-year period, conducted by Mohr and Bartelme in connection with Dr. Hess' clinic at Michael Reese Hospital proved that at the end of 4 or 5 years no difference in physical development could be detected between the prematurely born and the full-term children. (J. H. Hess et al.: *Physical and Mental Growth of Prematurely Born Children*. U. of Chicago Press, 1934.)

Mental development also proceeds normally in the premature group, although it is sometimes slower than in full-term children. There is a higher incidence of hydrocephalus among babies born prematurely, but this condition occurs almost entirely in infants who suffer intracranial hemorrhages. Retrolental fibroplasia, a condition that causes blindness, is prevalent among premature babies who weigh under 1,500 grams. It is interesting to note that the incidence of this condition varies in different parts of the country.

The job of saving premature babies has just begun. We need to reach more of them. We need more centers, more personnel, more equipment. We should develop research projects that will teach us not only to understand the problem of premature infants but also how to prevent their being born prematurely. We need institutes so that people in the field can become accurately informed. We should train more perpersonnel.

Though the excellent work of the American Academy of Pediatrics goes a long way toward throwing light into dark places, in many ways the medical profession needs a great deal of prodding. The Academy has published a manual, giving standards of care of newborn and of premature babies.

We need better reporting about work done and more accurate statistics. We should educate the public and the community to an appreciation of the whole problem. Hospital administrators should become enthusiastic proponents of our program because no part of a hospital creates more good will than its nursery for premature babies.

Every area should have access to a center for the care of premature babies, which in turn should serve as a teaching center and a research unit. The citizens of a community that has such a center can point to it with pride as a product of the true working of our form of government—democracy.

GORDON

(*Continued from page 154*)

Furthermore, the information gathered by the public-health nurses and the social workers have permitted us to individualize our criteria for discharge. For example, of 81 infants in the 2,000 to 2,500 gram weight group, 40 were hospitalized for 7 or fewer days, and of these 40, 26 were discharged on breast, or breast plus bottle. For the smaller infants, too, the drive has been toward as early discharge as possible. Not only does this decrease the period of separation of mother and infant, but it conserves our limited space, our limited expert nursing service, our limited finances for those infants who cannot be cared for any other way. During the year of survey, a total of 4,718 hospital days of care was given to the 165 surviving infants. Forty-one percent of the total bed-days was devoted to care for infants, while they weighed less than 2,000 grams, whereas 59 percent of care was given to infants while they weighed more than 2,000 grams. Our attempt will be to reduce the latter figure, and success will come only if we can transfer the responsibility for this care to the mother in the home, with the aid of the public-health nurse.

A word about the ultimate development of prematurely born infants. The best follow-up data—that of Dr. Julius Hess and his group—indicate that if a congenital malformation or injury is not present at birth the prematurely born infant will develop into a normal child. Not even the very varying risk of retrolental fibroplasia can serve as consolation for death of a prematurely born infant. The Lord was willing to save Sodom and Gomorrah for a very small percentage of the population—the prognosis for goodness of premature infants is much, much better.

We have tried to outline some of the aims of the Colorado State Program for the care of premature infants. In the long run the most effective methods of reducing mortality and morbidity must depend on concerted efforts of private and public agencies, as well as of individuals, and the State health department would appear to be the proper agency to give leadership.

COHIG AND MASON

(*Continued from page 158*)

tional, and environmental problems related to premature birth.

In the courses for nurses the medical social worker has served as a member of a panel. For these panel discussions one case has usually been selected to show the care given to the premature infant during hospitalization and after his discharge from the hospital. The social worker's part in these discussions has been to emphasize the medical social aspects of the situation and to interpret the service she has given. The less formal part of the social worker's "teaching" takes place during her daily association with the other members of the staff of the center by focusing attention on the social aspects of the baby's care.

The hospital social worker in attending ward rounds takes an active part, with the doctors and nurses, in following the baby's progress and helping to plan for his care. The social record is part of the medical chart, and its information is useful to the medical staff in planning the patient's medical care, in research, and in teaching.

Both medical social workers—the consultant and the hospital social worker—have held regular case conferences with the public-health nurses about certain of the infants who have left the center. They exchange information about the progress of the baby in the light of the family situation in his home. Through these conferences the medical social workers have had an opportunity to bring out the medical social implications and to give guidance in the utilization of community agencies to meet the needs. A deeper understanding between nurses and social workers has been developed and the functions of each have been more clearly defined.

The families of premature infants cared for in the Colorado premature-infant-care program have presented a variety of medical social problems. Through the cooperation of the different staff members of the center and of public-health nurses, physicians, and community agencies, an effort has been made to offer a number of premature babies the best possible care within the resources of the family, the community, official health agencies, and the center.

• FOR YOUR BOOKSHELF

MARY IRENE ATKINSON SPEAKING FOR CHILDREN. Cheney C. Jones and Gertrude Springer, Editors. Parthenon Press, Nashville, Tenn., 1949. For sale at Methodist Book Store, 810 Broadway, Nashville, Tenn. 192 pp. $2.50.

This book, from the frontispiece to "Mary Irene's Farewell," and all the pages in between, speaks to our minds and hearts of the vivid, generous, simple, yet profound personality of one of America's greatest friends of children. The sponsoring committee, and particularly the editors, have rendered a great service in bringing together the rich heritage found in the writings and speeches of one who played an important part in shaping trends in child-welfare work under both public and private auspices during the 25 years from 1918 to 1943.

The editors have done much more than assemble, select, and edit—they have woven the material together into a symmetrical whole, illustrative of major trends throughout this period, and the result is a book of compelling beauty, great compassion, homely wisdom, historical perspective, and philosophic insight.

Mary Irene's profession was social work, her specialty the welfare of children, her thought and action always bearing the stamp of a pioneer heritage and the relationships and happenings of a small midwestern town, yet she knew and was equally at home in every part of our country and in the thought and experience of past ages. Of her, Cheney Jones says, "She had come to know her United States. . . . She felt at home with any and all of us and talked a language we could all understand. The common people heard her gladly."

Children of the decades of the "twenties" and "thirties" badly needed a spokesman, and Mary Irene was a tireless pleader of their cause. Whether she was pleading for mattresses instead of iron slats in a children's institution, for china instead of enameled tableware, for some place where a child could keep his own things, or for development throughout the Nation of adequate organizational structure and administrative practices in child-welfare work, her motive was always the same—the ideal expressed in a quotation she used from Dr. James S. Plant—"Every child should be made to feel that he is a special blessing in the sight of the Lord."

Katharine F. Lenroot.

• CALENDAR

May 1–3—National Council of Juvenile Court Judges. Annual meeting. Pittsburgh, Pa.

May 1–7—National Correct Posture Week. Sponsored by National Chiropractic Association.

May 5–6—American Council on Education. Annual meeting. Chicago, Ill.

May 7–12—Biennial Nursing Convention. American Nurses' Association, National League of Nursing Education, and National Organization for Public Health Nursing. San Francisco, Calif.

May 7–13—National Hearing Week. Information: American Hearing Society, 817 Fourteenth Street NW., Washington 5, D. C.

May 7–14—National Family Week. Eighth annual observance. Sponsored by the Interfaith Committee on Family Life, representing Jews, Catholics, and Protestants. Information: Rev. Richard E. Lentz, International Council of Religious Education, 206 South Michigan Avenue, Chicago 4, Ill.

From May 8—Third World Health Assembly. Geneva, Switzerland.

May 8–9—Society for Pediatric Research. French Lick, Ind.

May 8–10—American Pediatric Society. French Lick, Ind.

May 14–18—Boys' Clubs of America. National conference. Washington, D. C.

May 14–19—International and Fourth American Congress on Obstetrics and Gynecology. New York, N. Y.

May 16–20—American Association on Mental Deficiency. Seventy-fourth annual meeting. Columbus, Ohio.

May 22–24—National Conference on Citizenship. Fifth annual meeting. Washington, D. C.

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Page 155, courtesy of Dr. A. L. Carson, Jr., Director, Bureau of Maternal and Child Health, Virginia State Department of Health, Richmond.

CHILD HEALTH DAY, 1950

By the President of the United States of America

A PROCLAMATION

WHEREAS the people of our Nation, believing in the dignity and worth of every individual, feel particular concern for the health and welfare of our children; and

WHEREAS our national aim is to assure to every child the chance to develop those physical, spiritual, emotional and mental qualities that make for individual happiness and responsible citizenship; and

WHEREAS we are dedicated to the achievement of that ambition, through democratic processes, for all our children; and

WHEREAS the great advances in knowledge and practice made in the last half century in assuring better health and security to our children have benefited great numbers but have not yet reached all; and

WHEREAS we propose to examine our achievements and our shortcomings in regard to child care at the Midcentury White House Conference on Children and Youth, to be held in December 1950, and to arrive at the greatest possible agreement on how we can demonstrate our determination to give every child the best possible start in life; and

WHEREAS the Congress, by a joint resolution of May 18, 1928 (45 Stat. 617), authorized and requested the President of the United States to issue annually a proclamation setting apart May 1 as Child Health Day:

NOW, THEREFORE, I, HARRY S. TRUMAN, President of the United States of America, do hereby designate May 1, 1950, as Child Health Day and I urge all citizens, individually and in their community, State, and national preparations for the Midcentury White House Conference on Children and Youth, to consider on that day the needs of children in their own communities and States and the best ways of meeting those needs.

IN WITNESS WHEREOF, I have hereunto set my hand and caused the Seal of the United States of America to be affixed.

DONE at the City of Washington this nineteenth day of April in the year of our Lord nineteen hundred and fifty, and of the Independence of the United States of America the one hundred and seventy-fourth.

Harry Truman

By the President:

Dean Acheson
Secretary of State

VOL. 14, No. 10 APRIL 1950

the CHILD

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FEDERAL SECURITY AGENCY
Oscar R. Ewing, Administrator

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Arthur J. Altmeyer, Commissioner

CHILDREN'S BUREAU
Katharine F. Lenroot, Chief

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the CHILD

NEW FRONTIERS IN CHILD HEALTH

NEOTA LARSON, Assistant Chief, Children's Bureau

THE WORD "FRONTIERS" is a good word, for it is close to the heart of our American way of life. There was a time in our history when we located a frontier geographically. But we now realize that a frontier may also be an area of new ideas, new ways of defining problems, new ways of trying to solve them.

There are many such frontiers in child health. Some of them are being pushed forward by the search for new knowledge that is going on day after day, year after year, into the causes of disease and of pathological conditions. For example, scientists and others are asking themselves why between 1,000,000 and 2,000,000 children in this country have hearing defects, and what can be done about these children. Again, many workers, knowing that about 200,000 babies are born prematurely each year, are trying to find out not only how to save the lives of these babies, but what are the causes of prematurity and how it can be prevented.

About 200,000 children in this country have epilepsy; nearly 500,000 are suffering from rheumatic fever; at least three-fourths of our children need dental care. We have come through the worst epidemic of poliomyelitis in our history. The men and women working on the frontier of caring for handicapped children are asking themselves if these things need be, or if they can be prevented. They turn to their test tubes. They work with these children in organized programs of care. Both groups see before them great possibilities in finding the causes of crippling if only enough persons devote themselves to the search.

Another frontier exists where the workers—all too few in number—are searching for information about how children grow and develop, what molds their personalities, what the inner drives are to which they respond, and how they are affected by the family and the community in which they grow up. These frontiersmen — and frontierswomen—are concerned with the day-by-day events of a child's life. They have already learned many things and have passed them on to help parents and others working with children.

They point out, for example, that physical and emotional health are two sides of a single coin. The baby who is put on a rigid feeding schedule unrelated to the time when he actually gets hungry experiences frustration and sometimes ill health as a result. The child who does not feel wanted and loved becomes anxious, and sometimes overly aggressive and negative in relation to life. He does not stand adversity as well as many children who outwardly appear to be less well-favored but inwardly know where they stand with the people who care for them. A child may fail to move from one stage of development to the next because he is afraid. If his bodily and his mental and emotional growth do not proceed in harmony, he may be more susceptible to colds, and to illnesses of greater severity. If his insecurity is great enough, he may end up with a mental illness.

Workers on this frontier are also finding out for us what happens to children whose parents are torn by anxieties about their ability to keep their jobs and pay their bills. They are weighing the effects on the growth and development of children coming from the culturally more rigid parts of our society. They are measuring the effects on children of growing up in homes of low economic status—children who feel themselves inferior and unable to compete with those who are more secure economically.

These workers have only glimpsed the promised land, but if they succeed in their researches, and if the other parts of the pattern fall into place, some day we may become a people who are emotionally mature enough to solve the problems of the world without the destruction of human life we have experienced in World Wars I and II.

There is a third frontier in child health that needs our attention: the translation of knowledge into skill in caring for children and in making ours the kind of society in which children have a reasonably good chance to grow up as well-adjusted human beings. This calls for placing knowledge in the hands of parents and professional workers to its fullest extent as it becomes available. There is hazard in this, just as there is in all ventures that carry us into new areas of planning and activity, for we may mistake judgments for facts and incomplete knowledge for its totality. But the greater hazard is in waiting, for while we wait children grow up.

Child's personality emphasized

This frontier—translating new knowledge into skill—is wide open for exploration. Parents and others responsible for children are constantly reaching out for help. The Children's Bureau receives more than a quarter million letters a year from parents and others serving children asking for the latest information about child growth and development and about the kinds of services that children ought to have, not only for their protection but for the full realization of their capacities. Teachers are turning their attention to how a child learns as well as to what he should learn.

Medical schools are beginning to give training that takes into account the relation between physical and emotional development in the child. Schools of social work and schools of nursing are putting more and more emphasis on the child as a growing and developing personality; asking how an illness that he has or a social problem in which he is involved affects the kind of a person he is or may become. The challenge that is before us is how to accelerate the rate at which this kind of skill can become a part of the equipment of those workers who care for and serve children.

The economic situation of rural families is generally lower than that of city families. Yet ¼ of the Nation's children in 1946 lived on farms, where only ⅛ of the national income went.

This brings us to a fourth frontier in the field of child health—how we can assure that such skill will become available in the form of service to children, everywhere as they need it.

We do not yet know the extent to which we can equalize the opportunities of children for good health throughout the Nation, nor the extent to which we will give priority to the needs of children in the use of our income and resources. This is a complex problem. There are no easy answers to it. Often we are tempted to dismiss it by saying that parents themselves must solve this problem. But we have a responsibility to find out if parents really can do this. We must bring into focus the economic and organizational facts which will help us in knowing whether parents can manage by themselves, out of their own funds and with the resources now available to them, to get the health services their children need and must have.

We find great variations in the economic ability of families to provide for their children. The facts that we have available show that, in general, as the number of children in the family increases, the lower the total family income is likely to be. Families throughout the United States had a median income of $3,031 in 1947. Incomes of families with one, two, and three children, which did not vary much from this figure, were $3,096, $3,180, and $3,120, respectively. But for families with four or more children—those responsible for one-third of the Nation's children—the mean income dropped to $2,731.

To realize the meaning of these figures, we need to know how adequate a $3,000 income is. One gage of how much money families need to provide the essentials of living is the budgets developed by the Bureau of Labor Statistics and priced for 34 cities in 1946 and 1947. An "average" of these budgets shows that in 1946 a family of four—including two children under 15 in school—needed at least $2,750 to pay for the most modest kind of living. At least 10 million children—close to 50 percent of all city children—were in families whose incomes failed to reach that amount. Of all the city children living below this tight budget, almost three-fifths were in families with three or more children.

The economic situation of city children is generally superior to that of rural children. Yet one-fourth of the Nation's children in 1946 lived on farms, where only 12 percent of the national income went.

Communities provide services

Obviously the child-rearing years are not the most affluent years in most families. Parents are young and are struggling to get themselves established. They have had no opportunity to build up a backlog of savings. For the most part, they live on their current earnings.

These are the kinds of economic facts we must keep in mind when we wonder why parents do not get their children's teeth filled, or their other physical defects corrected. In some countries—Great Britain, Canada, Australia, and Sweden—family income is augmented through a system of family allowances. This is one way to approach the problem. Another, the American pattern, has been to supplement family income by providing certain kinds of community services. We are already providing education at public expense. Both public and private agencies in the fields of health and welfare are assuming increasingly larger responsibilities for making other services available, for which there may be either no charge whatsoever, or a nominal one, to the family.

We must, then, try to find out whether communities can provide some of the services that children need. Here we find ourselves up against the same kind of problem. Not only are children concentrated in low-income families, but they are also concentrated in low-income areas and in low-income States. In other words, regions rich in children are relatively poor in income. The Southeast, for instance, at the time of the 1940 census, had a greater ratio of children to adults of working age than any other part of our country (57 children under 15 years of age for every 100 adults 20 to 64 years old). In 1948, the per capita annual income of this region, $957, was the lowest in the country. At the other extreme, the Middle Eastern States had 37 children per 100 adults of working age, and a per capita income of $1,647.

Changes that have taken place since 1940 in the distribution of the child population on account of family migration and increases in births, may modify these figures somewhat. But the changes are not likely to change the general pattern, which is that the greater the responsibilities for rearing children, the fewer adults there are of working age, and the smaller the income of the family and of the community.

This pattern holds for States as well as larger regions. At one extreme lies Mississippi, with 63 children for every 100 adults aged 20 to 64 years and a 1948 per capita income of $758 per year. At the other end of the scale is New York, with 32 children for 100 adults and a per capita income of $1,891.

According to estimates for 1948, white children in this country have a life expectancy that is 8 years longer than the life expectancy of children who are not white—mostly Negro children.

A high per capita income does not necessarily mean that a State, through public and voluntary effort, is providing services to its full capacity; but obviously, the lower the per capita income the less able a State is to support the services its children need.

Parents face still other problems in trying to provide the services that their children need. These center around the problem of actually having the services within reach, and so related to each other that a coordinated plan can be worked out for the individual child. A fortunate parent may be able to fly his sick child to a hospital in a distant city, but this is so rare that when it happens it is front-page news. On the whole, distance puts services beyond the reach of parents. Children are well served only when there is a qualified doctor and other professionally qualified personnel within a reasonable distance of their homes and when they have access to hospital care and the other services a child may need.

As knowledge increases, and as we undertake to translate this knowledge first into skill and then into service for children, we quickly move into a situation where neither the individual child's parents nor the individual doctor can solve the problem without help. State and local health departments, working with doctors and parents and voluntary groups, must assume responsibility for planning programs of care. Doctors will continue to practice in their private offices, or in groups, and they will man community clinics, such as maternity or pediatric clinics. But doctors, if they are to be fully effective, need to be practicing in places where there are public-health nurses and laboratory and other facilities. They should be able to obtain consultant services. This may require State-wide planning. There should also be, nearby, dentists specializing in the care of children's teeth; nutritionists; physical therapists; medical social workers; and other professional and technical workers as needed.

This may be easier to do in a metropolitan area than in a rural community. But there is ample evidence to show that a program of services is no idle dream. Every State in the Union has made a beginning in organizing such programs of care, through its maternal and child-health and crippled children's programs and through voluntary organizations interested in various aspects of child health. No State is without some successful experience along this line. But work still needs to be done in all States—work that eventually will equalize the opportunities of children to have services available, no matter what State they live in.

Evidences of what we can do as a people once we put our hearts and minds into the task can be found everywhere. In 1915, before the Nation had begun to work seriously on the problem of maternal mortality, the maternal death rate for the country as a whole was four times what it is now. In the same year, before we had begun our attack on the problem of infant mortality, the infant mortality rate was three times what it is now.

Toward preventing deaths of mothers

What happened in this interval? There are people in the Children's Bureau who can speak from personal experience about those early years, when the first efforts were made to define one of these problems, that of maternal mortality, and to find ways to work on it. The beginning was a very modest one. Children's Bureau staff, working in cooperation with other public and private groups, undertook a small study of the causes of maternal mortality.

Even before the first study was finished, medical societies throughout the country were awakening to the problem. Using the schedules developed in the original study, with such adaptation or modification as was needed, the doctors in State after State, working in cooperation with the State health agencies, set themselves to the task of determining not only the causes of death when mothers had died as a result of childbirth, but to determine whether such deaths were preventable. Practically every State medical society has had at one time or another a special committee, which investigated the circumstances surrounding each maternal death as it occurred.

Many of the findings have been startling. One State medical society, in a State with a relatively low maternal mortality rate, came to the conclusion in the middle 1930's that 75 percent of the maternal deaths in that State were preventable. Others came out with similar conclusions, and began to seek ways of improving the record.

Many people were involved, and many methods tried. The Sheppard-Towner Act was an early step in translating knowledge into services for the mothers of this country. Doctors in private practice worked on the problem. Voluntary associations did their part in this important work.

Not everybody was convinced, of course. There were many ups and downs. In 1929, for example, the opposition to the public program was so strong that the Sheppard-Towner Act was made a dead letter. In 1935 the services were revived as part of the expanded maternal and child-health services program under the Social Security Act.

States work to improve maternal and child health

The struggle toward positive health for mothers and children is replete with examples of this kind, differing in method and detail but much alike in general pattern. Every State now has maternity services in at least some places, under its maternal and child-health program, and all are expanding services in response to known need. Some States have taken steps to assure the availability of hospital and specialist care to mothers seeking help because of complications of pregnancy. Other measures are being taken to reduce infant and maternal mortality further, with public and private agencies and physicians in private practice working together for that purpose.

Commendable strides have been taken in reducing the common communicable diseases of childhood—measles, mumps, diphtheria, and whooping cough. By 1949 rheumatic-fever programs were operating in 25 States, under the direction of State agencies and with the help of Federal funds available for crippled children's programs under the Social Security Act. In many parts of the country, movements are under way to provide special care for cerebral palsied or "spastic" children.

With the help of Federal funds, special programs are being organized to provide service and care for children with hearing defects and for those with poor eyesight. States are beginning to plan for children who have epilepsy—to organize programs of service that will bring these children the benefits of the present knowledge about how to control this condition.

We could add many more examples. We have no reason for complacency, however. The fact remains that more than three times as many mothers still die in some States as in others. More than three times as many infants die in the State with the highest infant death rate as in the State with the lowest. Children still die of communicable diseases we know how to prevent.

We certainly have not solved the health problems of children in minority groups. Thirteen out of every 100 children under 20 years of age in the United States are nonwhite—Negro, Indian, or Oriental. At birth a nonwhite child, according to estimates for 1948, had a life expectancy 8 years shorter than that of a white baby. The maternal mortality rate in 1948 among nonwhite mothers was over 3 times as high as it was among white mothers. Infant mortality was over 1½ times as high among nonwhite as among the white. It is significant that in that year the average annual income of these families was only about half that of white families. Negro children, who make up 95 percent of all nonwhite children, live predominantly in localities that are below the national average in child health and welfare services and that have social and legal barriers separating white from Negro children.

This fourth frontier leads us into one of the most difficult areas of all, but it holds out much promise of reward in spite of the hazards involved.

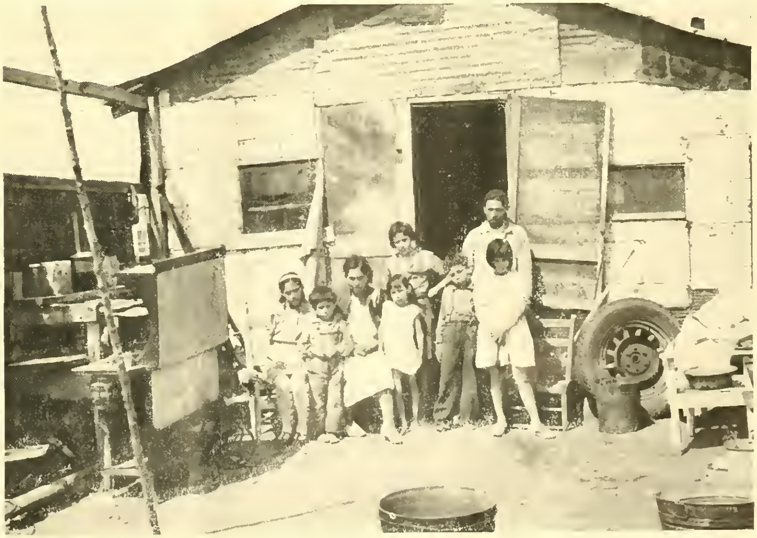
Action on these frontiers involves the kind of responsibility that we feel for one another in a democracy. All our efforts are important, whether we work as individuals, through our voluntary associations, or through our local, State, and Federal Governments.

If we are to solve the problems on these frontiers, people in every State of the Union must be concerned with the people in every other State. For some this concern may be primarily economic. The rural areas, where proportionately more babies are born, replenish the labor supply of urban areas. The cost of inadequate health services in rural areas therefore cannot be confined to those areas. For some the approach will be primarily humanitarian—a conviction of how good it would be if no child were to suffer a handicap needlessly, or to grow up without a full realization of his capacities, wherever he lives, whoever his parents are, whatever they earn. Or our concern may stem from many other reasons, valid to ourselves and to our way of life.

Toward new frontiers

It is not a simple picture that I have outlined. In some respects, it is not a clear picture. There are still many unexplored areas, and new knowledge will certainly lead us into new paths and uncharted areas, but the patterns are emerging. We know where the child-health frontiers lie, and we must forever push forward.

The families that have the most children are not as a rule those with the highest incomes.



ONE WORLD IN SOCIAL WELFARE

ELISABETH SHIRLEY ENOCHS, Director, Division of International Cooperation, Children's Bureau

ONE of the most difficult and challenging responsibilities confronting the field of social work in the United States today is that of sharing our experience with men and women from every part of the world who are coming to us on scholarships, fellowships, and travel grants under many different national and international auspices, and of broadening our own professional horizons by study in other lands.

The words "difficult and challenging" are used advisedly. For no simple formula will guarantee a successful program of international exchange in any field, particularly that of social work. The number of our international visitors increases year by year and may become even greater as a result of President Truman's proposed Point IV program of technical assistance to underdeveloped areas. Let us then review our experience of the past few years with international exchange, and, in the light of what it has taught us, plan together for the even heavier task that lies ahead.

To make human life fuller

In order that we may fully realize the significance of our task, we must consider it as one of the elements in that vast and complex network of activities known as international cooperation. Its importance was stressed by Dr. Lleras Camargo, Secretary General of the Organization of American States, when he said: "The day is approaching when any nation that does not serve effectively the fundamental interests of the human species, both within its frontiers and beyond them, is headed for oblivion. Man, the international and supernatural creature, is the chief concern of the new foreign policy . . . . The only thing we should fear is failure in our efforts to make human life a fuller one for those who eagerly long for this."

Such a political philosophy should provide a fertile field in which to sow the seeds of international cooperation. But the sowing of seed is merely one of the first, and often the easiest, of the steps that lead to the harvest. It is the long period of cultivation, requiring wisdom, patience and skill, that will spell the difference between success or failure.

If, as Dr. Lleras affirms, man is the chief concern of the new foreign policy, then the social worker should play an important role in the formulation and execution of this policy. This gives new meaning to the training of social workers, from the national as well as from the international point of view.

Some of the implications of this new foreign policy have been emerging slowly in recent years. Insofar as the United States is concerned, they have grown out of the Inter-American Conference for the Maintenance of Peace, held in Buenos Aires in 1936, and the Eighth International Conference of American States held in Lima in 1938, which laid the foundations for our first official program of international cultural cooperation.

The Buenos Aires Convention for the Promotion of Inter-American Cultural Relations was approved by Congress in 1937. The Federal Security Agency's Office of Education is the administrative agency. According to the terms of this convention, which has been ratified by 17 countries of this hemisphere, each country may submit each year to each of the other countries a panel of 5 names, from which 2 prospective fellows are selected. Travel may be paid either by the sending country or by the student. Maintenance is paid by the host country at rates varying from a maximum of $200 a month in the Dominican Republic to a minimum of $33 in Chile. The average grant is $100.

Since this program was inaugurated, five social workers have come to the United States as Buenos Aires Fellows, among them a fellow from Chile, who spent a year at the New York School of Social Work, has since helped to inaugurate the School of Social Work in Bolivia, and is now directing the school of social service established by the United Nations in Guatemala. A fellow from Costa Rica is now head of the Section of Cooperatives in the Pan American Union. In addition, two students each in the fields of sociology and psychology and one in psychiatry have received Buenos Aires fellowships for study in the United States. Unfortunately, not a single social worker from our country has taken advantage of this means of spending a year of study and observation in Latin America. The Office of Education would welcome applicants in the social-work field. Schools of social work exist in Guatemala, Costa Rica, Panama, and Cuba, and quotas for these countries have not been filled. In view of the fact that we may soon be called upon to provide more training opportunities for citizens of some of the underdeveloped countries of the world, would it not be appropriate to fit ourselves for this responsibility by learning more about such countries at first hand? The Buenos Aires fellowships offer opportunity to do so in nearby countries and the Office of Education is eager to receive applications. (Argentina, Ecuador, El Salvador, and Uruguay are not parties to the convention.) And possibilities will be offered through the Fulbright Act.

The inter-American program with which people are most familiar is that initiated under authority of Public Law 355, the "Act to Render Closer and More Effective the Relations Between the American Republics," of 1939. This is the program under which the great majority of the Latin American fellows have been coming to the United States. It was just 10 years ago, in the

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Given at a joint meeting of the International Committee of the American Association of Schools of Social Work and the Steering Committee of the Conference on International Interchange of Social Welfare Personnel of the National Social Welfare Assembly, Atlantic City, N. J.

Children and adults wait at a tuberculosis clinic in Asuncion, Paraguay. Not only do health problems come to light at such a clinic, but also many problems of social welfare.

autumn of 1940, that the Chief of the Children's Bureau invited representatives of the American Association of Schools of Social Work to serve in an advisory capacity to the Bureau in developing its inter-American program. That was the beginning of the AASSW's present international committee. The first project was that of sponsoring a visit to this country—and attendance at the 1941 National Conference of Social Work—by the directors of the 15 schools of social service then existing in the other Republics. The Coordinator of Inter-American Affairs paid the travel costs. That was the first project under which any group of social workers was brought to the United States by a Government agency—in fact, it was the first such project undertaken by the Coordinator's office, and it served as a pattern for others. The Inter-American Cooperation Committee of the AASSW remained in existence to sponsor two subsequent projects developed by the Coordinator's office and the Children's Bureau. These were fellowship projects under which graduates of the schools in Latin America were brought to this country for a year of study in schools selected for them by the AASSW. Some of them remained 2 years and are now doing pioneer work in their own countries. It is from those pioneers that we have learned many a valuable lesson from which other fellows assigned to us have benefited.

Since 1941 the Children's Bureau has been one of several Federal agencies receiving annual allocations of funds from the Department of State for inter-American cooperation, but until 1947, when the Federal Security Agency's Bureau of Public Assistance first participated fully in the program, it was the only agency awarding training grants to specialists in the field of social work, except for the Department of State itself, which, through its Division of International Exchange of Persons, has, from the beginning, made travel grants to specialists in this field.

Passage of the Smith-Mundt Act in 1948 made the program international. Under its authority our Government can also send specialists abroad.

With the ending of the war, UNRRA began sending fellows to this country from China and other war-devastated lands. The Department of State, with funds from the President's Emergency Fund, granted full fellowships to a few students from the Near and the Far East for study at schools of social work. This same fund enabled the Children's Bureau, in 1946, to select an expert for a 2-year assignment to teach medical social work at the Tata Institute, and to send two consultants to the Philippines.

National governments also began to send social workers to us. The trickle soon grew into a stream, and with the launching of the fellowship program of the United Nations in 1947, the program became truly world-wide. During the last 2 years we have also had fellows in the field of social welfare from the occupied areas—Germany, Austria, and Japan. The National Social Welfare Assembly and the Federal Security Agency have planned programs for large numbers of these. Our schools of social work have also received many students brought in on their own scholarships, or scholarships made available by voluntary agencies which had been pioneering in this field long before the Government entered it—the Federation of Settlements, the Red Cross, the Scouts, the YWCA and YMCA, the Association of University Women, the General Federation of Women's Clubs, and the National Council of Jewish Women, not to mention the various foundations, national and bi-national agencies, and the churches. The Institute of International Education administers many of these fellowship programs.

Opportunities described

The United Nations has published a bulletin entitled "International Exchange of Social Welfare Personnel," based on information received from 30 countries and many universities and schools of social work, in which the exchange opportunities available in the field of social welfare is set forth in great detail. It describes all existing and contemplated arrangements (fellowships, scholarships, direct-exchange schemes, etc.), for the training of social-welfare personnel in countries other than their own, and discusses such important questions as selection procedures, the determination of fields of study and operational aspects of exchange programs. Information on international scholarships and fellowships has also been published by UNESCO.

I should also like to mention a remarkable book entitled "The Cultural Approach," by Ruth McMurry and Muna Lee, published in 1947 by the University of North Carolina Press, in which the authors describe the cultural-exchange programs developed by France, Germany, Japan, the U. S. S. R., Great Britain, and several of the Latin American Republics, and show that the United States is a very late comer in a field in which France was the pioneer.

It is precisely because our country is a late comer in this field, and because of the ever-increasing size of the program, that we must take stock of our resources, coordinate our efforts, profit by the experience of others, and try to be worthy of the high expectations that our visitors bring with them when they come to study at our schools of social work or to visit our agencies.

We must face realities

In taking stock of our resources, we have to bear in mind the many different backgrounds from which our students and visitors come, the kind of work they are doing, and the resources they will have to work with when they return to their homelands. In this connection I often remember an article written by Mattie Cal Maxted of the University of Arkansas a few years ago, in which speaking of rural social work, she said: "No profession makes progress by training a group of workers by some theoretical standard, and then trying to find something for them to do * * * a profession grows out of the realities of the experience of its practitioners."

In order to make a wise selection of the resources we use for training or observation for our foreign friends we must first learn something of the "realities of their experience." There is no theoretical standard that will offer equal satisfaction to a specialist from Scandinavia and a professionally untrained but hard-working practitioner from an underdeveloped country. Although we still tend to offer them too much in too short a time, fortunately we have passed the stage when only "the biggest and best" was fit to be shown to the stranger within our gates. Well do I remember the almost tearful gratitude of an official from Latin America who, after visiting a modest agency in a rural area exclaimed: "This is the first thing I have seen that could be adapted to our conditions! Until now I have only seen palaces and things far beyond our means!" And another who said: "How grateful I am to have had my fellowship in the United States in wartime when you were all having such difficulties and your services were shorthanded! What you call an emergency is with us a normal condition. But your emergency has taught me valuable lessons I could not have learned otherwise. I have learned that there are certain standards that must not be sacrificed and what you do to preserve them when your resources are extremely limited."

On the other hand, there are the problems presented by the visitors who arrive full of an enthusiastic conviction that something known as "case work" can be readily learned in three easy lessons, and that social work, as developed in the United States, is a matter of formulas and techniques which can be learned and applied with almost mechanical efficiency. Then, too, there are the students who insist that case work can have no possible application in their country and close their minds to it entirely. But most disappointing of all is the student who returns from a year of study or a full course and a degree, having mastered the terminology of social work but not its basic concepts and whose work in his homeland is a matter of outward and visible signs, completely lacking in inward and spiritual grace.

Fortunately such cases are not numerous. They may be the result of poor selection. We may be sure that their number will decrease as selection procedures are further improved and as we, in turn, gain more knowledge of what the foreign student needs and more skill in applying that knowledge.

Let us now focus attention on what we have previously described as the difficult and challenging responsibility confronting the field of social work in the United States; namely, that of acquiring the knowledge and the skill that will enable us—*all of us*—to meet the needs of our fellow workers, whether they come from Sweden or Saudi Arabia, France or Iraq, the United Kingdom or Afghanistan. For this is a total effort, we might almost say part of the total diplomacy needed to carry out this new foreign policy, the chief concern of which is man himself. If the United Nations, through its Department of Social Affairs, represents the highest expression of this new concept in international relations, the smallest social agency in our most remote community may represent an equally important part of it, and the citizens who support that agency and who make up the community it serves may be among the most valuable interpreters of its function and meaning.

Let us heed a warning, voiced by Dr. Lleras, that "if we fail to realize that we are living through a revolutionary period we shall continue to react to its phenomena with the outmoded attitudes, methods, and equipment of the past and unwittingly suffer the consequences."

Before we undertake to share our experience with all the world, let us first be sure that what we have to share is as good as we can make it. Let us not be misled by the sheer numbers of our foreign visitors or flattered by their choice of the United States as a country for study and observation. We must be honest about our shortcomings and be brave enough to look at them through the eyes of our foreign visitors themselves. One of our Mexican neighbors, who spent a year in our country under the auspices of the Children's Bureau, summarized his experience in a thoughtful and, on the whole, most complimentary report, which contained this final observation: "The results achieved to date are frankly gratifying among the white population. They are not as satisfactory as might be desired—as you yourselves affirm—among the Negro population for various reasons which there is no point in analyzing. . . . The democratic principles of the Constitution of this country and its advanced laws establish no differences between one group of citizens and another. Consequently, from a strictly legal and logical point of view it is not possible to have two health and welfare services, one for the white and one for the Negro population. . . . This, I am sure, is merely one of the residual manifestations of ancient divisions or special situations affecting groups and communities, with roots going deeply into the social, racial, or historical movement of the Nation and which, little by little, will undergo dilution."

A specialist from Sweden said to us that the United States may be considered as leading in the institutional treatment of juvenile delinquents—not because of the general pattern, which he considers rather a bad one—but because of the work of a few advanced institutions in which, more than in any country he had visited, he had found complete acceptance of the individual boy or girl as a human being in need of understanding, sympathy, and support. Our visitors are generous in viewing our shortcomings when they see that we face them honestly and are sincerely trying to correct them.

Priorities in social-welfare interchange

The first responsibility of the social-work profession to the rest of the world, therefore, is to do a good and honest job here at home in training our social workers and in developing our social-service programs and to enlist all of our training facilities and all of our agencies in a vast cooperative effort toward this end.

Another responsibility is that of looking beyond our own frontiers, in order to gain more knowledge of the peoples and problems of other countries. Unless we do this we shall never be able adequately to meet their needs, or our own, for that matter. Our social workers have been relatively slow to take advantage of opportunities to study abroad. This is not due to selfishness or lack of interest. In view of the pressing needs of the postwar world, the first duty of our people has been to give and to share. But the peak of the emergency has passed. In order to give more fully we, too, must study and observe the realities of experience that differs from ours. Let us resolve to take advantage of the possibilities afforded by the Buenos Aires Convention, by the Fulbright Act, by the exchange programs of the United Nations and its specialized agencies, by the Institute of International Education, and the various other national and international, public and voluntary agencies which offer facilities enabling social workers of one country to study, travel, or observe in another.

To the extent that we make constructive use of such opportunities, we shall be making it easier to discharge our first responsibility—that of doing a good and honest job here at home. The fact that the world is knocking at our doors, seeking to learn from us, should not lull us into the complacent belief that we ourselves have nothing to learn. On the contrary, there are few countries that have nothing to teach us. Well do I remember a Mexican visitor who was impressed by the novel method whereby a rural community without telephones raised a white flag on a conspicuous landmark to signal to the health authorities that their presence was urgently needed. He then learned that the county health officer had borrowed the idea from rural Chile. There are many ingenious resources devised by our fellow social workers in countries where programs do not follow our pattern, which could usefully be adapted here if we but knew about them. Who can deny that the rural areas of our own country might benefit from a "bold new program" of technical assistance in the field of social welfare? Perhaps, when we count the results of Point IV, we may find that we have learned more than we have taught, and received far more than we have given. Let us hope that this may be so.

Need high-quality leaders

An additional responsibility of which we must ever be conscious is that of sharing what we do and what we know in the most constructive manner possible. It will not be easy to meet the many demands that will probably be made upon us in the years ahead. With the growth of the various programs of interchange in the field of social welfare, under both national and international auspices, it will be necessary to build up multiple sources of leadership. Upon the quality of that leadership will depend success or failure.

In days gone by people believed that any kind of teacher could teach the primary grades. We know better today. By the same standard the recruitment of social workers for service in the underdeveloped areas of the world will challenge the best our countries have to offer. These leaders must possess maturity and flexibility, vision and imagination, patience and forbearance, the gift of interpretation and adaptation, and the ability to see things whole. They must be singularly aware not only of the cultural patterns of the people of those remote areas but of the impact which programs of economic development will have on them. They must be able to share in developing new types of community organization and resources and training programs at the fifth grade as well as the university level. They must have the courage to remind us from time to time that economic development is not an end in it-

Typical of newer developments in Latin America is this shop in a training school for delinquent boys, called "Colonia Suarez." The school is maintained by the Uruguayan Government.

self, but a means to an end, a means of furthering this new foreign policy, the chief concern of which is the welfare of man.

Those who have traveled through some of the lonely parts of the world know that men and women of this type are often found in the most unexpected places. They may be missionaries, teachers, doctors, nurses, social workers or members of other professions, or of no profession except that of service to their fellow men. The war revealed many of them, as did UNRRA. But there are not enough. We must develop new sources of leadership. And this, perhaps, is one of the most difficult challenges we face, one that will rest most heavily upon our schools of social work and our agencies.

When Winston Churchill realized that the fall of France left England to stand alone against her foes, he is reported to have said: "You know, I find it rather inspiring." We too may find inspiration in this challenge if we view it in its proper historical perspective and realize that we are living through one of the periodic stirrings which bring to our world new vigor and enlightenment.

Child-welfare consultants succeed

Whenever I am inclined to be disheartened I think back to a day, nearly 10 years ago, when the Department of State asked me to appear in person before members of the Senate Appropriations Committee in order to justify the $15,000 which had been included in the State Department's budget for the inter-American program of the Children's Bureau. It was my first appearance before that august body and I was frankly terrified. When the committee heard that one child-welfare consultant would be assigned to Brazil—a country larger than the United States, underpopulated, underdeveloped in many areas, and with most difficult means of communications—one of the members swept his palm across the long mahogany table as if it represented the whole continent of South America and said, with a pitying glance at me: "What can one lone woman do in that vast country down there?"

The answer has come. Last year a representative of the Department of State who visited the American Republics reported on his return that the work our consultant had done was the best piece of work by an individual consultant that he had observed on his inspection tour, and only recently our Embassy in Rio reported that virtually every State in Brazil is clamoring for her services. She has demonstrated what one lone woman can do in a country larger than ours. So, too, has another consultant who has worked in remote mountain villages of the Andes and the new jungle settlements of the Peruvian hinterlands, where she was associated with the projects of our Department of Agriculture. Our Embassy in Lima has just reported to the Secretary of State that "because of her personality, thorough knowledge of her specialty, good knowledge of Spanish, easy adaptability, and understanding nature, she may be considered the American specialist who has made the most important and lasting contribution to our cultural effort in Peru during 1949."

In less-developed countries social-welfare programs and community organization often begin with a day-care center for children of working mothers. This one is in Asuncion, Paraguay.

I do not apologize for mentioning these members of the Children's Bureau staff. I realize that the Bureau has been nothing more than a channel through which American social work has been enabled to share, during the last decade, in writing the first chapter in the history of a new phase of our country's relations with the rest of the world. They represent our country—what it is and what it stands for.

Our philosophy of social work, deeply rooted in our democratic traditions, and with its emphasis on the individual, which these consultants took with them to other lands, was their most important tool in building bridges of understanding between ourselves and people of widely different backgrounds. As long as we adhere to this philosophy we need not fear to experiment with some of the bold new patterns which the execution of bold new programs may require.

In what proved to be his last message to us, Franklin D. Roosevelt's undelivered address, written the night before his death, contained these words: "Today we are faced with the preeminent fact that, if civilization is to survive, we must cultivate the science of human relationships—the ability of all peoples, of all kinds, to live together and work together in the same world, at peace."

Social work has an indispensable contribution to make to the science of human relationships. May our contribution be such that all who are reached or affected by it will echo the sentiments of a student from Europe brought to this country by the National Council of Jewish Women: "Here," she said, "I learned the real meaning of the dignity of the human being."

HOMEMAKER SERVICE HELPS A MOTHERLESS FAMILY

MARJORIE H. BOGGS, *Family Service Association of Cleveland*

NOT FOR expediency does a casework agency send a homemaker to a family. Supplying this kind of service when the mother is unable to care for her children (usually because she must be away from home) is a part of case work. Whether homemaker service is the most suitable answer to a family's difficulties is determined, not alone by its need for this service, but by that family's ability to use it well, as with any case work.

This story is about long-time service

It should be said at the beginning that this discussion deals only with homemaker service given over a long period to families without a mother. The service is used also, and much more frequently, in the care of children when their mother is away for a short time—for instance, when she is ill in a hospital. The presence of the homemaker, who is a member of the agency's staff, prevents the uprooting of the children.

In these short-time situations the homemaker is expected to maintain the home as it is, to meet the children's ordinary needs, and to deal with their day-to-day problems—all in cooperation with the father. The mother also, except in extreme emergencies, still has a part in planning the children's care. Sometimes she is in the home but is unable to take care of her household.

In these situations the principles underlying the service and the skills employed are the same as in long-time care, but the purpose, the responsibilities, and the relations between the family and the agency staff members are somewhat different. In fact, there are many differences between providing a homemaker to care for children for 2 or 3 weeks and providing one to help a father bring up children who have lost their mother.

The relation between the homemaker and the parent who is at home calls for careful handling by the case worker from the first moment of the parent's request to the agency. This is especially true when the service is to be a long one. The case worker must be sure to make clear to the father the agency's purpose in offering him homemaker service and the conditions under which it is offered. Otherwise he has no real choice about how he wants to solve the problem created by his wife's permanent absence from the home. If he wants only a housekeeper, not appreciating the emotional needs of his children, he will surely think of himself as the homemaker's employer and will think of the case worker as an interfering busybody to be avoided.

In helping the father to see clearly his motive in asking for the service,

A social agency sends a homemaker into a motherless family not only to keep the home intact, but also to help to give the children the comfort and understanding that every child needs.

Condensed from a paper presented at last fall's meeting of the National Committee on Homemaker Service, held at New York City. *The Child* is publishing this paper in two parts, the second part in the June issue. (This is the fifth in our series of articles on homemakers, which began in August 1947.)

the case worker should make it quite plain that an agency homemaker will not displace him in his role of parent and head of the household. The homemaker goes into the home to supplement the parent's care. The case worker keeps her contact with the family to help both the parent and the homemaker make the investment that the agency is making in the children as worth while as possible.

Loss of mother dislocates home life

Prolonged or permanent absence of the mother often distorts the character development of children. The degree of distortion depends on many factors. Some of the factors are the quality of the relation between the mother and her child before the child loses her: the essence of the child's feeling toward the mother at the time as related to his emotional development, his age and the degree of his psychic emancipation; and the circumstances of his mother's death or departure. Other factors are the child's relations with his remaining parent and that parent's capacity to understand and ally the child's fears and grief; the presence or absence of relatives and other persons from whom the child gets a feeling of security; and the amount of dislocation in family living that the mother's death or departure has caused.

The reason a case worker can serve a family by supplementing the efforts of the parent and the homemaker is that she understands these factors that may distort the child's character development and other factors in his situation. It is her business to know what every child needs for sound physical, social, and emotional development, and to be able to ascertain which of these needs is not being met in a family.

It is well known to those who work with children that a child who has had a secure, loving relation with his mother suffers a tremendous loss at her death, but he does not suffer emotional injury so much as one who had a feeling of insecurity with his mother and conflicting feelings about her. The emotional injury results in an intensified sense of guilt because of hostility he had toward his mother.

It is commonly thought that a young child will soon forget his loss and so be unaffected by it. The case worker knows, however, that the worst time for a child to lose his mother or father is before he has worked out for himself his identification with both parents and before he has learned to separate fact from fantasy and to deal successfully with his own mixed feelings.

A parent who knows how to use help will sense the deep concern and understanding of the case worker and will see the reason for the three-way partnership of case worker, homemaker, and parent. The homemaker, having been trained for the job, is intellectually aware of the reason for the partnership. Threats to her usefulness do not come from misunderstanding this relation but from her own emotional needs. She may withhold information that might reflect on her own competency. She may identify her interest too closely with the family and feel that she is protecting them by concealing from the case worker unfavorable facts about the parents or children.

Homemaker service involves human relations

Problems in human relations cannot always be avoided but they can be resolved when the persons concerned with them function on clearly defined principles, have a common aim, and trust each other.

Perhaps a review of the way one situation developed during the service of a case worker and a homemaker will answer some of the questions asked about this service. The review—necessarily brief—may help to make clear this way of caring for children deprived of their mother permanently or indefinitely, by showing, in part, the management of the multiple relations involved in providing homemaker service.

Mr. B came to the Family Service Association of Cleveland because a policewoman told him his children needed a woman in the home. She said, "Family Service will give you a homemaker." Neighbors had reported to the police that the children were not getting proper care and supervision.

Mr. B explained when he first came to the office that since his wife's death a year before, her father had looked after the children. Mr. B himself worked hard and long to make a living for them so didn't have much time to "be a mother." He couldn't have held his family together without the children's grandfather, but he realized that Grandpa was getting on in years and was less and less able to keep up with six active children. The oldest girl had been a big help, and his mother came in once a week to do the family wash.

The B children were 14-year-old Ann (Mrs. B's daughter, adopted by Mr. B), Martha, 8, Bobby, 7, Jack, 5, Laddie, 3, and Freddy, not quite 2.

Did the family really need this service?

The case worker's first task was to determine whether the family really needed and wanted a homemaker and could work with one. The grandfather, father, and children had managed their own affairs for a year and would not have sought help at this time except for interference from neighbors.

All through the 3 weeks before the agency supplied a homemaker, Mr. B thought the service sounded like a wonderful thing for his family. He was realistic in working out what portion of the cost he could carry, and he was willing to abide by agency limitations. He readily gave information about the children's health, habits, and ways, showing ability to individualize them. He realized that Grandpa might be difficult about the coming of the homemaker but felt sure he could handle this. He agreed that Ann and Grandpa should be in on the planning.

The chief point on which he could not be helpful was a specific, illuminating description of his wife. He could make only general, highly favorable statements about her. The case worker saw clues for later use as to the possible meaning of this overemphasis on favorable factors about his wife and his self-blame in telling the story of her death. She had been killed in an automobile accident while she was driving a roomer to the train. Mr. B had intended to take him but was tired and Mrs. B insisted that he rest—that she would enjoy the drive.

When the case worker talked with Ann, the girl accepted the idea of a homemaker outwardly but was sure that her sister wouldn't like it. Martha was used to doing things her own way, Ann said, and would feel that the family was getting along all right without anyone. The case worker realized that Ann was voicing her own reaction, but she did not try to discuss this directly. Instead she talked with Ann about all the mixed feelings that Martha might have, that any child might have in similar circumstances, and left Ann convinced that Ann, the worker, and the homemaker would be able to meet problems as they arose.

Ann thought also that the baby, Freddy, might have trouble getting used to the change. He was only 9 months old when he lost his mother and so seemed to think Ann was his mother. This information the case worker handled in the same way—as Freddy's problem, not Ann's. She said it was a natural way for Freddy to feel. She was thus able to assure Ann indirectly that she wasn't going to be displaced in the family's affections. She said that no one could replace a mother but that Ann and the homemaker would try to do a good second-best job. Ann could in this way be freed to do more of the things a 14-year-old girl wants to do.

Grandpa wasn't so sure how things would work but agreed on the surface that the job was getting to be too much for him. He would not give information about his income or plans for sharing it. He said he had always contributed what he could to the household and would continue to do so. But he had his plans for old age and his business affairs to consider. He said, without conviction, that he knew it was not good for children to have too many bosses, and that he would be glad to let the homemaker do the directing.

It seemed clear that Grandpa would not step aside easily and might test the patience of any homemaker sorely. The case worker found, however, that the old man had quite a sense of humor and an ego easily inflated by a little praise.

With the family members prepared, financial plans agreed on, and division of responsibility considered, the next step was to select a homemaker who would be suitable for this home. It was agreed in a conference of staff members responsible for the choice that the one selected to work in this particular home should have natural affection for children, skill in guiding them, and the infinite patience of a diplomat. Expectations about her housekeeping skills would not be high because apparently housekeeping standards in the home had never been high. It was clear too that meal planning and the cooking would not cause conflict.

Homemaker meets the family

Of the homemakers available, the one chosen as the most likely to succeed with the B family was first given a thumbnail sketch of the situation by the supervisor of homemaker service. Then the case worker, after giving the homemaker pertinent information about the different members of the family, took her to call on them. This is a procedure established to give the homemaker and the family a chance to see whether they feel they can work together and to decide jointly, with the case worker there, on who should carry the main responsibilities, on working hours, and on other practical matters.

How much of what the case worker has learned about members of the family and their problems does she share with the homemaker? That is always a major question. The answer depends somewhat on the homemaker's capacity to understand and use the information wisely. It is always well for the case worker to speak in advance about the troubles she is pretty sure will arise but not to suggest those that may not happen. What did the case worker know of the individuals who made up the B family and what did she deem essential to share with the homemaker?

The case worker knew that Mr. B had a steady work record, provided for his family, and intended to maintain the home at any cost. He seemed tired and under considerable strain. These facts could well be given to the homemaker. She would be in a better position than the case worker to evaluate

A homemaker knows that getting along with the children is more basic than her other duties.

the real quality of the father's relations with his children.

The case worker saw Mr. B as essentially a passive man, too ready to deprive himself of advantages in order to meet the expectations of others. He had given incidents of Grandpa's treatment of the children that showed he was aware of their resentment but was unable to interfere. Grandpa was doing his best and they couldn't have managed without him.

Mr. B had had a break-down some 2 years before his wife's death. This "complete physical exhaustion" he attributed to having worked 12-hour shifts during the war. He described physical symptoms, gastrointestinal in nature, present before and since his break-down. He had never talked about himself, he said, and found it hard to do so. Actually, he revealed nothing of his innermost feelings.

Nothing would be gained from telling the homemaker that the father's physical symptoms probably were due to emotional causes. The case worker hoped that relieving him of some of the heavy home burdens might prove to be enough to lessen the symptoms.

Family story unfolds

Of Mrs. B the case worker could learn nothing vital for the homemaker to know. She knew from another agency's record that Mrs. B had become illegitimately pregnant at 18. She married the father of her baby, Ann, a month before her confinement. But she never really lived with this husband because her parents couldn't allow her—their only child—to leave them. The marriage had been dissolved. Mr. B told the case worker only that his wife had a daughter before they married. He had adopted Ann and had always thought of her as his own. Mrs. B's parents had lived with the family from the start. The mother died shortly after the marriage but the father had stayed on. The case worker had reason to suspect that Mr. B's marriage had not been as happy as he seemed to want to portray it. Whether or not he would be able to use help other than homemaker service remained to be seen.

These few facts would tend to raise questions about the family's life before Mrs. B's death, rather than to answer them.

Ann, the case worker knew as a relatively normal adolescent, making "A" grades in school and taking part in activities of her age group. Before her mother's marriage to Mr. B the little girl had been cared for by her mother's mother while her own mother worked. She was 5 years old when Mr. and Mrs. B married and Mr. B adopted her, so she started to school with the family name. How much she knew of her own parentage the case worker did not know.

Grandpa said that Ann was the image of his daughter, and Mr. B referred to her as being like her mother and as being a real help to him in caring for the younger children. To what extent she was being cast in this role of "little mother" by her father and grandfather rather than choosing it herself was a question. Ann had said that Freddy thought she was his mother, but at the same time she seemed to have rather normal interests outside the home.

The position Ann had held in the home for a year at least, and her possible reactions to having another take over, the homemaker would need to understand. The basic training of all the women who do this work gives them an intellectual understanding of child development and the relations between children and parents. This homemaker had worked with adolescent girls before, but certain factors made this experience different. They were the presence of Grandpa, with his highly emotional relation to the family, and Ann's adoption. The homemaker was not told about this adoption because we did not know how much of a factor it was in the minds or emotions of any of the family. No difficulty might materialize from it.

Martha, Mr. B's first-born, who is almost 7 years younger than Ann, seemed a bubbling, friendly, and normally mischievous child. Mr. B said she was really the grandfather's favorite—that he spoiled her so she was getting sassy and high-handed with the other children. She showed no major problems that needed to be discussed in advance with the homemaker.

Bobby, 7, stood out as the "problem" member of the family. His father told the case worker he was failing in school, had been greatly affected by his mother's death, still asked for her, and often cried out in his sleep. As the first boy, he had been his mother's favorite, Mr. B thought, and she had allowed him to remain too dependent on her. The grandfather openly disliked Bobby, and though the father was sympathetic toward him, the boy's behavior was obviously an added cross for him to bear. He hoped the homemaker could help Bobby; he himself hadn't known how to "make up to him."

Case worker helps with problems

When the case worker first saw Bobby she described him as "tall, thin, and anxious appearing." He met her first overtures with a skeptical gaze, then impulsively ran to her, sobbing, "I failed, I'm not going to pass." The case worker put her arms around him, told him she knew he had been having a tough time but she was going to try to make it better for him so he would pass next time. He lapped up her affection, then ran to get his mother's picture to show her.

Bobby's first reaction to the homemaker, however, was: "Go back home, I don't want you." But, when the effervescence of the other children over her arrival lessened and they went about their business, he showed a little interest.

It was evident that the case worker would need to talk Bobby over pretty thoroughly with the homemaker. His close attachment to his mother and the injury he suffered by losing her suddenly was the only explanation for his behavior the worker could pass along with assurance. She told the homemaker, "It will be hard for you but it will be good for Bobby if you can help him talk about his mother, and it will be good for him to be allowed to keep her picture in view." The case worker offered other suggestions such as watching her own emotions lest a warm response to Bobby's great need make the other children jealous.

The younger children showed no outstanding problems. None of them had had consistent training or discipline for the past year, it was evident, and what they had had before that was a big question.

(*To be concluded in the June issue*)

• IN THE NEWS

Summer Courses

Columbia University. New York School of Social Work. New York 28. Three series of summer institutes in social work. Some of the courses in Series II: New trends in adoption; the psychosocial development of the child; case work with children. Series I, June 19–30; Series II, July 10–21; Series III, July 24–August 4.

Louisiana State University. School of Social Welfare. Baton Rouge 3. Some of the short courses: Juvenile delinquency (June 9–30). The child and the community; supervision in social case work; trends in social welfare (July 3–22). Workshop in welfare administration (July 24–August 12). Some of the 9-week courses (June 9–August 12): Social services for children; children in foster care; visiting-teacher work.

Smith College. School for Social Work. Northampton, Mass. Graduate seminars for experienced social workers, organized around three general aspects: Social case work, psychiatry, and supervision. Two new topics added last year will be continued: Teaching of case work and case-work writing and interpretation (July 10–20).

University of Chicago. Chicago 37, Ill. Summer Workshop in Human Development and Education, sponsored by the Center for Intergroup Education. The workshop is for teachers; guidance workers, school psychologists, and counselors; administrators, principals, and supervisors; librarians; and community workers. It is designed to develop effective leadership skills in human relations in a variety of areas. (June 26–August 4.)

University of North Carolina. Department of Sociology and Anthropology. Chapel Hill. Seminar in intergroup relations, for social workers, teachers, other professional workers, and lay community leaders (July 21–August 29).

University of Pennsylvania, the Public Health Service of the Federal Security Agency, and the Pennsylvania State Department of Health, cooperating. Hygiene Building, University of Pennsylvania, Philadelphia 4. A 5-week summer course in family living and sex education, for teachers, counselors, social workers, and public-health workers (June 26–July 28).

Western Reserve University. School of Applied Social Sciences. Cleveland 6, Ohio. Public-welfare workshop includes five courses: The case work implications of budgets and financial management; care of children outside their own homes; supervision of case workers; problems of unmarried parents and children born out of wedlock; and current problems in public welfare (June 26–30).

Our Lady of the Lake College. The Worden School of Social Service. San Antonio, Tex. The session has been planned for two specific purposes: To meet the needs of full-time students who have completed a block of field work and to offer beginning and advanced courses for the employed staff of health and welfare agencies and for visiting teachers and counselors. Among the courses are: Social case work; use and interpretation of mental tests and measurements; principles and practices in child welfare; organization of social work; community organization; methods in the practice of social group work; and philosophy of social work (June 19–July 28).

Books on Rehabilitation To Be Exhibited

The National Society for Crippled Children and Adults, which publishes a monthly bibliography for workers with the handicapped, entitled *Bulletin on Current Literature*, has prepared an exhibit collection of books in print on rehabilitation. This exhibit collection is available for showing at National, State, and local meetings, and at workshops and institutes attended by workers in the medical, social-work, educational, and allied professions. Further information may be had from the Society, 11 South La Salle Street, Chicago 3, Ill.

• FOR YOUR BOOKSHELF

PSYCHIATRY IN A TROUBLED WORLD, by William C. Menninger, M. D. The Macmillan Company, New York, 1948. 636 pp. $6.

Those who work with children may see little interest in a book about army psychiatry. If, however, the premise that an insecure soldier is a product of an insecure childhood is valid, a theme well developed by Dr. Menninger, it provides a stimulus to do better work with children. In this book the mechanics of production of emotional disturbances in soldiers are not only well discussed but are well related to early difficulties. Dr. Menninger has utilized this retrospective theme in the discussion of the soldier's role, the officer's role, the problems that arose in all soldiers, and the therapy that was used to meet these situations.

Certain special problems, frequently overlooked because of their emotional connotation, are fully presented. One is the problem of the mentally defective soldier.

Another is the problem of homosexuality, and Dr. Menninger describes the confusion that arose out of the friction between moral ideas and psychiatric knowledge.

The book is long but it reads well and should sustain the interest of anyone interested in human beings. The chapter on civilian experience entitled "In Peace" had probably best be tackled in a separate sitting from the section "In War."

Henry H. Work, M. D.

• CALENDAR

May 22–24—National Congress of Parents and Teachers. Annual convention. Long Beach, Calif.

May 22–June 18—General Conference of UNESCO. Fifth session. Florence, Italy.

May 28–June 3—General Federation of Women's Clubs. Annual convention. Boston, Mass.

June 5–7—President's Conference on Industrial Safety. Washington, D. C.

From June 7—International Labor Conference. Thirty-third session. Geneva, Switzerland.

June 15–17—American Hearing Society. National conference. Chicago, Ill.

June 18–20—National Congress of Colored Parents and Teachers. Twenty-fourth annual convention. Kansas City, Mo.

June 26–29—American National Red Cross. Annual convention. Detroit, Mich.

June 26–30—American Medical Association. Annual session. San Francisco, Calif.

June 26–30—American Physical Therapy Association. Twenty-seventh annual conference. Cleveland, Ohio.

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Page 174, Paraguayan Government.
Pages 175 and 177, Arthur M. Vinje, Madison, Wis.

We Inventory Research in Child Life

With the publication of *Research Relating to Children*, prepared by the Children's Bureau Clearinghouse for Research in Child Life, we have for the first time a pattern of the current research in the United States relating to children. Obviously the bulletin is not complete, for its sources of information are the many workers in many fields who voluntarily sent in reports of their projects. No solicitation plan could be expected to reach all workers, nor can all workers be expected to have a desire to cooperate. That 1,600 reports of ongoing research have been assembled from a great many fields and from a large number of agencies indicates that communication has been established and interest has been aroused.

The amount of the material is heartening to research workers, for it shows more vigor than many thought existed. Of course the caliber of the reports varies, from studies of the simplest sort to complex, long-range undertakings. Some show real imagination, and give promise of producing fundamental facts. Others are designed to answer immediate practical questions. Irrespective of the quality or depth of the projects, it is encouraging to know that so many people are interested in finding out things about children. That the seeking spirit exists in so many professional fields gives promise of real expansion of our knowledge.

One would hardly be justified from this material in attempting to be definitive about the direction in which research is headed. As succeeding editions of the bulletin come out, trends will probably emerge. From the present compilation one can see that many people in a variety of fields are engaged in studying children. The extent to which research relating to children is interdisciplinary is not discernible. Many different disciplines are studying child life, but how closely they are working together on common problems is not clear.

In this review of research certain areas of activity are evident, which when related to current problems give life and a sense of importance to the undertakings. The growing interest in child-rearing practices and in their cultural differences is reflected in the number of studies in this area. Another sign of our times is the amount of interest shown in problems of minority groups.

What are the gaps in research? How does the reported material relate to planning for research? Planning an over-all program of basic research is no more practical nor productive than planning for what the country needs in art or literature. One can plan the production of certain pictures or of a series of textbooks, but like great art and great books, great scientific discoveries come out of the minds of men, irrespective of command or demand. In the field of operational research we can, however, plan. The need for answers to questions in certain fields can be defined. People concerned with children are asking not only "whys" but "hows." Much in research is pedestrian and unexciting; but answers to practical questions can mean much to human happiness. Though we need to keep as a major objective the protection and support of scientists who are capable of delving into basic research, we should not look on applied research as lacking in value or outside the sacred circle.

This compilation of research brings to light the meagerness of present efforts to answer some of the questions we know people are asking. Are comics good or bad for children? How many premature infants can be saved by a good program of care? How can I get my child to sleep enough?

A program of research to meet the practical end of answering questions such as these can be facilitated by a review of what is going on. Unjustified duplication can be avoided and interrelated effort increased. The dangers inherent in policy planning for research can be avoided if broad areas to be explored are defined, and, more important still, if emphasis is placed on the training in research techniques of people with ideas and imagination.

Katherine Bain

KATHERINE BAIN, M. D.,
Acting Director, Division of Research, Children's Bureau.

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Managing Editor Sarah L. Doran
Art Editor Philip Bonn

FEDERAL SECURITY AGENCY
Oscar R. Ewing, Administrator

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Arthur J. Altmeyer, Commissioner

CHILDREN'S BUREAU
Katharine F. Lenroot, Chief

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the CHILD

A PROPOSAL FOR JOINT ACTION AGAINST CONGENITAL SYPHILIS

BETTY HUSE, M. D., *Pediatric Specialist, Program Planning Branch, Division of Health Services, Children's Bureau*

W. H. AUFRANC, M. D., *Medical Director, Assistant Chief, Division of Venereal Disease, Public Health Service*

WHEN A CHILD has been infected with syphilis by his mother before he is born, we call his disease congenital syphilis. A better name would be "negligent" syphilis, because, as doctors have pointed out repeatedly, negligence is the only reason today for any child in the United States to be born with syphilis.

Yet some 100,000 children in this country, 10 or younger, are estimated to have undiscovered congenital syphilis. Any one of these children is a candidate for blindness, mental deficiency, physical deformity, or premature death. Not one of them should have been born with syphilis.

For the past 4 years penicillin has been widely available, and effective for the treatment of syphilis. Nevertheless, about a third of the 14,000 cases of congenital syphilis reported each year are children 4 years old or younger.

The venereal-disease program is concerned with eliminating syphilis from the population. The maternal and child-health program is concerned with the health of mothers and children. When babies are infected during their mother's pregnancy, the mandate for joint action is unmistakable.

We therefore propose joint action by the venereal-disease and maternal and child-health programs—to find and treat every syphilitic pregnant woman and to find and treat every newborn syphilitic baby.

As a basis for joint action, the Public Health Service and the Children's Bureau have agreed upon certain basic procedures:

1. We recommend that at least two blood tests for syphilis be made as a routine part of every woman's prenatal care—one early in pregnancy, the other late in the third trimester or at the time of delivery. This recommendation is of sufficient importance to merit consideration for legislative action.

2. Since a pregnant woman with untreated syphilis is a medical emergency, we recommend that she receive treatment at once.

3. For those mothers who receive no prenatal care prior to delivery, we recommend a blood test for syphilis at the time of her admission to the hospital. If the test is positive, the mother should be treated. Treatment of the mother, even when given immediately before delivery, offers some protection to the baby.

THIS CHALLENGE to doctors, nurses, and all other health workers in contact with expectant mothers and newborn infants to help in wiping out congenital syphilis appears simultaneously in *The Journal of Venereal Disease Information* and *The Child.* Each reader of *The Child* will receive, in addition, a copy of the July issue of *The Journal of Venereal Disease Information*, which includes, besides this article, discussions of the following topics:

The Present Status of the Treatment of Syphilitic Mothers and Children.

How to Interpret the Results of Kahn Tests in Infants.

The Role of the Dentist in Finding Congenital Syphilis.

4. For all babies born of untreated or inadequately treated syphilitic mothers, we recommend that a blood test for syphilis be made as soon as possible. (The filter paper microscopic (FPM) test promises to be satisfactory and to eliminate the difficulty of obtaining venous blood from a baby. For a discussion of the FPM test, see "Filter Paper Microscopic Test for Syphilis, or the FPM Test. A Preliminary Report," by R. B. Hogan and S. Busch, in the February 1950 issue of *The Journal of Venereal Disease Information*.) A positive test of the infant's blood may not indicate the presence of syphilis; similarly, a negative test may not indicate the absence of syphilis. If the chances are not good that the physician will be able to observe the infant over a minimum period of 4 months, he may wish to give protective penicillin therapy. If the physician elects to delay treatment, it will be on the assumption that his chances for observing the child for a minimum period of 4 months are very good indeed. If signs of syphilis do not appear within the first 4 months and if the blood test is negative at that time, it is extremely unlikely that evidence of congenital syphilis will appear later.

5. Even if the mother has been treated for syphilis, either before pregnancy or early in pregnancy, we recommend that the infant's blood be tested for syphilis at birth. If the test is positive, although this does not necessarily indicate congenital syphilis, the physician's decision to give protective penicillin therapy should depend, as before, on whether or not he will be able to observe the baby for at least 4 months. If the test is negative and if the mother's syphilitic status is quiescent, there is little or no likelihood that congenital syphilis will develop.

We have recommended that every pregnant woman be given at least two blood tests as a routine part of her prenatal care. If this recommendation is to be carried out successfully, we must enlist the pregnant woman herself as a partner. She must be encouraged to request blood tests for syphilis as a routine part of her prenatal care. Maternal and child-health services throughout the country are in a position to reach a large reading and listening audience of pregnant women. The venereal-disease public-appeal program can reach an equally large audience.

To broaden VD contact work

The workers in venereal-disease control should plan to broaden their emphasis in epidemiology and case-finding so as to include not only contact interviewing and contact tracing on primary and secondary syphilis but also to make certain that examinations for syphilis are performed on all children of syphilitic mothers and on all brothers and sisters, as well as parents, of children with congenital syphilis to insure that no case of congenital syphilis goes undiscovered and that other cases of congenital syphilis do not occur.

We should also enlist the general practitioner and the obstetrician in our search. All State maternal and child-health programs maintain continuing relationships with these physicians. Many of the State medical societies have a maternal and child-health committee, with which the maternal and child-health division of the State health department works very closely. (This collaboration has made possible many studies of maternal deaths, the findings of which have been of material assistance in reducing maternal mortality in this country.) Here is an established mechanism that can be put to good use in the field of congenital syphilis. Where the medical society has both a venereal-disease committee and a maternal and child-health committee, they might work together.

Perhaps some combination of the two committees and the two divisions could study each reported case of congenital syphilis, going back to the prenatal history to find out just why the disease had not been prevented. Such a study would shed light on the specific measures that should be taken in the State to tighten up case finding and treatment among pregnant women.

Through refresher courses, institutes, seminars, talks before medical societies, and publications, professional education can be provided for doctors, nurses, medical social workers, nutritionists, and others who come in contact with pregnant women.

Many pregnant women are cared for, if at all, by midwives. In 1947 midwives delivered about 176,000 babies in the United States, most of them in Southern and Southwestern States. In many of these States the maternal and child-health division of the health department is concerned with trying to raise the standards of midwife care. Where there is a State law concerning midwives, licensing and regulatory powers frequently are vested in the maternal and child-health division of the State health department.

This nurse is taking a sample of the baby's blood for the new FPM test for syphilis. Although the test is still in the evaluation stage, preliminary work has given promising results.

We are not very hopeful of raising the midwife standards dramatically, but it has been possible, through law, regulation, or persuasion to get some of these maternity patients to a doctor for at least one examination. Added effort might cause this to happen more often, and the doctor giving the examination could be persuaded to test the woman for syphilis the first time he sees her and again late in the third trimester.

In some States welfare funds are made available for the medical care of welfare clients, including pregnant women. The child-welfare division of the welfare department, in some States, takes considerable responsibility for the care of unmarried pregnant women, including the arrangements for their medical care. The maternal and child-health division of the health department can alert the various welfare departments to the necessity for testing pregnant women at least twice.

Many health-department clinics are satisfied with *one* blood test during the prenatal period, and this may be responsible for some of the failures to prevent congenital syphilis. This situation should be corrected.

We have recommended that since a syphilitic pregnant woman is a medical emergency she should receive treatment at once. The physician should report the case immediately to the health department, and treatment should be started without delay. Many of these patients can be treated in rapid-treatment centers or in beds contracted for in hospitals. Perhaps even more could be treated in these centers if the maternal and child-health division were to help out with delivery facilities, obstetric consultation, and the satisfactory care of the well children who must sometimes accompany their mothers to the centers. The maternal and child-health program frequently has consultants on pediatrics, obstetrics, nursing, medical social services, and nutrition. They can be called upon to help.

It is frequently difficult or even impossible for a woman in the last trimester of pregnancy to leave home long enough for rapid treatment at one of the centers. In such cases, the maternal and child-health service might help to arrange for treatment in a prenatal clinic, hospital clinic, or doctor's office.

As part of every woman's routine prenatal care, she should have at least two blood tests for syphilis. One should be made early in pregnancy, and another in the last 3 months.

We have recommended that if a mother has received no prenatal care prior to delivery, a blood test for syphilis be given her at the time of her admission to the hospital. To make this testing effective as an instrument in our search, the rapid processing of blood tests on this group of patients is essential. This can and should be done. Rapid processing is especially important in these days of short maternity stays. Since the maternal and child-health program is concerned with hospital facilities and with the standards and procedures related to maternity care, it should be helpful in promoting this testing in hospitals. Most State programs have an active hospital consultation service. Their relationships with the obstetric and pediatric staffs have been influential in improving hospital practices for the care of mothers and children.

We have recommended that babies' blood should be tested at birth if they are born of syphilitic mothers who have not been treated, or who have been treated before pregnancy or early in pregnancy. Success in accomplishing this, as well as in assuring appropriate treatment and follow-up, depends primarily on the understanding of physicians—general practitioners, obstetricians, and pediatricians—and on hospital policies. Here again, the maternal and child-health program can help through its relationships with hospitals and with doctors who are taking care of mothers and children.

But what of the children of syphilitic mothers who, by some chance, have not been blood-tested or treated in the neonatal period? Case finding among babies and preschool children has presented many difficulties, not the least of which has been that of obtaining blood from a vein. But with the filter paper microscopic test or some similar one it should be much easier to find these children in the future. The maternal and child-health service should be able to find cases through the well-child clinics and through the physicians and clinics that provide health supervision to babies and young children.

The question is frequently raised as to whether a routine blood test should be made on all school children. This probably would not be worth while if attempted on a national scale. However, in some areas of relatively high

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HOW DOES A CHILD DEVELOP A HEALTHY PERSONALITY?

MELVIN A. GLASSER, Executive Director, Midcentury White House Conference on Children and Youth

DEVELOPMENT of healthy personality is a process of great complexity . . . and a process of immediate concern to each of us. For years science has explored the nature of personality and the intricate steps of its growth. Now, more than ever before, it is imperative that we examine the results of these investigations and determine how the knowledge we have acquired can best be applied to the benefit of our children and youth.

The purpose of the Midcentury White House Conference on Children and Youth is to determine what research now reveals about children and what more it must inquire into, and to study the practices of parents, teachers, social workers, and others who deal with young people. We must search out the "true knowledge" which, as Plato says, "compels to action." And we must transpose this knowledge into action.

For the purpose of assembling information that throws light on what contributes to healthy personality development, the National Committee of the White House Conference has appointed a technical committee on fact finding, whose national staff includes a group of physicians, welfare workers, and other workers in various fields concerned with children, under the direction of Helen L. Witmer. Committee and staff together are undertaking to sift and sort the conclusions of pertinent scientific inquiry that has already been made. They are examining these conclusions under the white light of interdisciplinary study, bringing them into a meaningful pattern, identifying what we know with sufficient certainty to put into practice, and calling attention to still-unconquered problems.

What, first of all, constitutes a healthy personality, and is it the same in all cultures? How do relations with other people affect the child in infancy, in childhood, and afterward? How close is the relation between healthy personality development and parental attitudes? What psychological devices do children use in order to adapt to parental attitudes? Is it true that personality is largely set by the time the child is, say, 6 years of age? Can later experiences throw a child's good adjustment out of balance? Can he adjust to poor emotional conditions at home if outside conditions are favorable?

How close is the relation between parental attitudes and development of healthy personality?

Of course, other factors also affect personality development. What, for example, of physiological conditions, like the effects of the mother's emotions on the child before he is born? What effects have such things as body type, endocrine balance, illnesses and physical handicaps, diet and nutrition?

And, of course, there are environmental factors growing out of social and economic conditions. In this connection we need to ask, does our American way of life impose more strain on personality than that of other societies, or less?

Is poverty detrimental to healthy personality development in and of itself? Or is it injurious because of people's disappointment and frustration in a culture that puts a premium on material success? Or is it that poverty brings too early and too frequent exposure to overcrowding, worry, tension, and other evils?

Examples suggest scope of inquiry

Is the presence of diverse cultural groups in our society favorable or unfavorable to personality development? What do prejudice, discrimination, and segregation do to the personalities of the children toward whom they are directed? What of the children who are the object of prejudice? And what of those who exercise it?

How does religion affect the development of healthy personality, and in what circumstances does it create problems? What happens when there is a lack of aesthetic and spiritual influences in everyday life?

These are examples selected from a long and detailed inquiry. They serve in some measure to indicate the scope of our fact finding and even suggest its flavor. The possible wellsprings of healthy personality are not being sought entirely in the small child's family experience, but in all the significant forces at work in our society and culture. Nor is any one of these to be viewed apart from the others, since interpersonal relationships, cultural patterns, and social and economic conditions are closely interwoven in the pattern of the individual's living and growing.

Since all the factors that would seem to affect healthy personality development (with the exception of the purely constitutional) exert their influence through social institutions, it is essential that these institutions, in their turn, be examined in the light of basic information about what healthy personality development requires.

For this reason, specialists on the conference fact-finding staff are studying some of our institutions. These include the family; schools; churches; health services; recreational opportunities; libraries, museums, and art activities; employment services and conditions; social services; courts and correctional agencies.

For example, in one section of the fact-finding report the staff will present what is known about the different cultures in the American scene. It will discuss child-rearing customs, the place given to the child in the family, patterns of harmony and of conflict, attitudes toward body functions, cleanliness, health, and food. It will discuss various attitudes toward authority, discipline, and education; concepts of life, death, and time; the place of religion in the life of the group and the individual, and the role of the church.

For the various disciplines concerned with the study of personality development, such an examination of different cultural environments with different ideals of personality should furnish new insight into the factors involved.

For direct services for children, such as those concerned with health, recreation, education, welfare, and the like, such discussion should furnish a background for distinguishing between behavior that is culturally consistent and behavior that expresses individual difficulties.

The fact-finding staff of the Midcentury White House Conference on Children and Youth is not operating in isolation, nor is anyone so naive as to anticipate that any findings leadenly offered at the time of the meetings of the conference in early December would constitute much more than a report to be filed, unless the channels for putting the recommendations into action are developed.

Accordingly, definite steps are being taken to develop an intent throughout the country to which these findings will give more solid basis, a movement to which they will contribute more accurate direction, a momentum they will accelerate. At the request of the President of the United States, Governors of all States and Territories have appointed White House Conference Committees, and these, in turn, are stimulating local discussion, inquiry, and activity throughout the country. Fifty-three such committees are already at work in every State, in Alaska, Hawaii, and the possessions.

Several hundred national organizations devoted to the interests and welfare of children are setting up discussion groups, evaluating their programs in the light of the conference theme, and initiating projects and studies closely related to it. Young people are at work on all aspects of conference activity and coordinate their interests and contributions through an advisory council on youth participation. Finally, 37 departments, agencies, and bureaus of the Federal Government are making studies and contributing to the conference activities their rich resources of technical skill and experience.

At the time of the conference meeting in December 1950, the results of all these various efforts will be brought together in the form of a series of reports—the national fact-finding study, the report of national organizations, the report of the work and findings of State committees, and, possibly, other reports from special groups.

In the light of all the information before them, several thousand participants will formulate principles, draw up recommendations, and suggest lines of post-conference action.

There lies before us the extremely difficult task of translating for our situations and purposes what is scientifically valid concerning man and his growth. This holds for doctors as well as for teachers, for social workers and parents, for group workers, and for all those to whom people turn for counsel and guidance. It holds, too, for anthropologists, sociologists, economists, political scientists, and all students of the behavior of man. None of them is finding the going easy. To a degree each tends to go his separate way.

The conference meetings provide opportunity to come together to scrutinize, to assess, to sort the sure from the doubtful, to fit together what should go together, to think and plan creatively for our own special fields and for all fields together, with the same great general ends always in mind.

In development of healthy personality what is the influence of give-and-take among children?

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SAVING EPILEPTIC CHILDREN

WILLIAM G. LENNOX, M. D.

Associate Professor of Neurology, Harvard Medical School, Chief of Seizure Service, Children's Medical Center, Boston

EPILEPSY is predominantly a disorder of youth. The words of Aretaeus[1] written early in the Christian era cannot be bettered: "It fixes its abode in the better periods and in the lovely season of life." With respect to the numbers involved and the seriousness of the handicap, convulsions are a major problem of childhood, and yet epilepsy has been the Cinderella of medicine. The fairy godmother of public interest has been busy elsewhere.

Of what importance is this disorder? Numerically it outranks many better-publicized diseases. A survey conducted by Thom [2], with the aid of the Visiting Nurses Association of Boston, disclosed that 7 percent of the children had experienced one or more convulsions during their first 5 years. Assuming that an equal proportion had a first seizure in the 13 years that follow, then something like 3 million persons 18 years of age or younger have experienced this unpleasant symptom. Fortunately, in most of these people, the convulsions were limited to a few, or even one, or occurred only under the aggravating condition of a febrile illness. Of the men screened for military service in the First World War, 1 in 200 was rejected because of epilepsy.

A considerable proportion of the persons subject to seizure are denied productive employment. And approximately 50,000 epileptics of all ages are supported in public institutions at a yearly cost of at least 20 million dollars.

Epileptics can live normal lives

Unlike some of the other nerve-crippling conditions that occur in childhood, the symptoms of epilepsy for the most part are due not to structural damage to the brain, but rather to an abnormal physiology. Consequently, sudden and dramatic relief of symptoms often follows institution of therapy.

Turning to the economic side of the problem, we know that huge savings could result from the general use of our newly gained knowledge. For example, let us assume that persons under 21 who have been diagnosed as epileptics number 200,000, and also (very modestly) that full use of present-day knowledge would change 1 in 10 of these from a state of dependency to one of self-support. The cumulative economic contribution by these restored persons during their working years, whether in earnings, or—as with a housewife—in services, would approximate 1 billion dollars, and a like amount would be duplicated in each generation. Facts like these will attract more attention if and when governing bodies give weight to the possible returns from spending.

Dollars can be counted; but peace of mind and happiness of heart cannot be measured or weighed, and yet are important factors in any health-saving program. An epileptic child can depress the spirits of the whole family and subject the parents to a lifetime of anxiety and hopelessness. Witness the case of Samuel L. Clemens, who sought everywhere, but without success, for relief for the seizures of his youngest daughter, Jean. Just before she died he and she were living alone, preparing for a cozy Christmas together. But on Christmas Eve she died in a convulsion. The father spent a snowy Christmas writing an eulogy of her. "God rest her sweet spirit" were the last public words that the great humorist ever wrote; he himself died 4 months later, his death from coronary heart disease doubtless hastened by that tragic event.

Again quoting Aretaeus, "If the mischief lurks there until it strikes root, it will not yield either to the physician or the changes of age, but lives with the patient till death." Epilepsy is being pulled from this age-old slough of despond by two strong arms, research and public enlightenment. In the past 15 years research has demonstrated the value of the electroencephalogram (record of brain waves) in the diagnosis and treatment of seizures and has led to discovery of more effective anti-epileptic drugs. Enlightenment has come, not only to doctors, but also to the general public. But just as faith without works is dead, medical discoveries that do not reach the sick might as well be cast down the drain.

News of better methods of diagnosis and treatment flows to the sick through many channels. Some channels are direct (the patient's doctor); some are indirect (the school teacher or the discerning friend or neighbor). Much information on health simply percolates through the soil of public awareness, fed by the printed page or the publicly spoken word. Indirect channels of information are especially important in correcting social and psychological ills that result from popular misconceptions and prejudices.

However, direct medical aid to the handicapped requires concerted effort both by professional workers and by lay persons who have the required knowledge and the essential interest to help those with epileptic seizures. If water is to reach distant parched fields there must be main reservoirs of supply. In terms of the problem of epilepsy, there must be centers for the training of doctors and of associated personnel. Such centers must not be stagnant, but must constantly be refreshed and enlarged through the inspiration of research. An adequate number of patients and a cooperating public, professional and lay, are presupposed. An example of such a center is the Seizure Unit of the Children's Medical Center of Boston. This is cited, not as an ideal nor even as a highly successful arrangement, but simply as an illustration of how a group may function. The experience of clinics now organized in other sections of the country would be just as applicable an illustration.

As to the name, "Seizure Unit," our clinic is first of all for diagnosis; questionable or borderline cases—children with febrile convulsions, breath-holding spells, temper tantrums, nightmares, or bad behavior that might not be epileptic in origin—are welcomed. Since the word "seizure" implies a broader coverage than "epilepsy," we use the former term in our title. Placed in one of the teaching hospitals associated with Harvard Medical School, this unit benefits from the continuous efforts in research and treatment that have been carried on for the past 29 years in some of the hospitals associated with this school.

The objectives of the unit are fourfold: Diagnosis, treatment, training, and research. The diagnostic-consultation service is for both clinic and private patients. Afternoon clinic sessions are held three times each week, all visits being by appointment. One session is for a limited number of new patients (four to six). Another session, much larger, is for return visits, and a third is for new and old patients in the age group from 12 to 18 years. The teen-age group is especially important because epilepsy so often begins during puberty and because this period poses special psychological and social problems. Boys and girls requiring special examinations with a view to possible brain surgery, and those requiring immediate care for an acute condition, are referred to the hospital ward; these children, however, make up less than 5 percent of those treated.

Each new patient, before being seen, is first questioned and examined in the morning medical clinic and his brain waves are recorded. A complete history and an electroencephalogram are the most necessary elements for diagnosis and advice about treatment. Three Grass instruments that make simultaneous tracings from eight points on the scalp are available. At the session for new patients each case is discussed in detail by staff and visiting doctors. The complete electroencephalographic tracing (not simply a report) is studied. After the diagnosis and the method of treatment are decided upon, this opinion is typed into the record, and a copy is sent to the referring doctor. Uncomplicated cases sent from the medical department are returned to it. Children whose condition present unusual difficulty and those to be treated with experimental medicines report at about monthly intervals, on the day assigned for return visits. Patients coming from a distance are seen at much longer intervals.

The staff includes three full-time doctors—a neurologist, a pediatrician, and the incumbent of a 6-months' fellowship. The last-named may be a fledgling specialist in any department of medicine, provided he has a sustained interest in epilepsy. In addition one or two pediatricians assist only in the afternoon clinics. There is also a full-time social therapist, a psychologist, electroencephalographic technicians, and five secretaries. Other qualifications being equal, persons who are epileptic are preferred.

This technician is watching a record of brain activity, made by an electroencephalograph. The patient whose brain is being studied by means of this device is in an electrically shielded cubicle on the right. Waiting their turn are two sisters—identical twins—both of whom have epilepsy. Electrodes and attached wires have been applied to the scalp of one of the little girls.

As a part of the training function, a turnover of personnel is not discouraged.

The work of the full-time staff members is done in eight rooms, two of these used as the laboratory for one of the electroencephalographs. Private patients are examined and treated in these quarters: this gives younger members of the staff experience with persons of a different economic and social level. Adults as well as children are seen as private patients, fees from such service contributing to the support of the unit.

Numbers and areas served

Quality rather than volume of work is stressed. In addition, the clinic aims to function as a consultation service rather than as a long-term treatment service. The knowledge and the cooperation of referring physicians are thereby encouraged, and the inevitable tendency of attendance to "snowball" is avoided. Therefore, the majority of patients seen at their initial visit are returned to the medical clinic or to the referring doctor or agency for continued supervision. A minority require clinic care because control of their seizures is difficult or because experimental medicines are being given them. In the year 1949 there were 1,402 visits by patients, representing 562 individuals. A little more than half of these came from the metropolitan area of Boston and surrounding towns and approximately 10 percent from States that border Massachusetts.

Training and research

The fellowship doctor and those assisting in the clinic, after becoming experienced, are expected to employ their knowledge in the community in which they settle. The clinics are attended by nurses and internes of the hospital, by groups of nurses from other hospitals, and by an occasional school teacher or social worker. Especially interested are foreign visitors. The guest book of the unit contains names of doctors from 22 foreign countries. Outside the clinic, lectures on epilepsy are given to undergraduate and graduate nurses, to social-service and medical students, and at medical conventions.

An active research program yields a better understanding and improved treatment and stimulates the interest of the staff. Strangely enough, pediatricians have been less active in this area than certain other specialists, and the field of inquiry should yield many treasures of knowledge now buried. Subjects of recent or present investigation are: The clinical correlates of the fast and slow spike-wave formations of the electroencephalogram; a clinical, psychological, and electroencephalographic study of epileptic twins, a group that now numbers 115 pairs; intelligence tests of 300 children who are private patients; analysis of the medical and social histories of patients; and clinical evaluation of certain antiseizure drugs that have proved successful in the control of convulsions in animals.

Medical and surgical therapy

We prefer to speak of relief or control of seizures rather than of cure. The period when epilepsy characteristically begins is a crucial period for treatment. Successful early control may prevent a lifetime of dependency or institutional care. Expert determination of causes and prescription of treatment are, therefore, especially important. The possible causes of seizures are multiple.

Persons with seizures can be placed in one of four groups. The distribution of 2,000 office and clinic patients of all ages is: First, persons with a family history of epilepsy or of migraine in a blood relative (33 percent). Second, those without any genetic history of the disease but with evidence of brain damage that antedated the first attacks (15 percent). Third, persons with a history of the disease, both genetic and acquired (11 percent). Fourth, the unassigned, those without any suggestive family or personal history (44 percent).

Although many children, perhaps a third of all cases, present evidence of brain damage, only a small minority require brain operation. All other cases (and also those operated on) must take medicine regularly for a considerable period of time. Fortunately the skillful use of present-day drugs—phenobarbital, dilantin, mesantoin, tridione, paradione, or phenurone—as well as the newer techniques of neurosurgery, permit a saving of seizures that 15 years ago could not even be envisioned. Certain medicines are especially effective for certain kinds of seizures. For example, brief but frequent periods of blackout of consciousness are called petite absence or petit mal. These belong peculiarly to childhood and have been notoriously resistant to drug therapy. Our unit has been a principal proving ground for the medicines tridione and paradione. More than 250 persons with this particular type of seizure have been treated, of whom approximately two-thirds have been greatly benefited and one-third completely relieved of this form of attack. The skillful and persistent use of medicines now available can control or greatly reduce seizures for the majority of children affected. Even partial relief can bring a radical improvement in family happiness and in ability to mount the educational ladder.

A representative patient of ours is called Kathleen O'Brien. She is a smiling Irish child of 11, who, after a blow on the head several years ago, had been having multiple convulsive seizures—not severe, but recurring 5 to 15 times a day and preventing her attendance at school. Medicines failed to control the seizures, and Kathleen's mentality seemed affected (her I. Q. fell to 70). Even a brain operation proved useless, but different medicines were tried persistently, and finally the right combination was reached. The child has not had a seizure for many months. She is again in school, and her I. Q. has risen to 109. The outlook, formerly so grim, is now cheerful. Kathleen is the most grateful of patients and readily takes part in clinic demonstrations and in interviews over the radio.

Psychosocial therapy

Medical treatment is only a portion of the task that faces the staff of a treatment center. In a clinic for children social therapy assumes a more varied role than in an adult clinic. This is because the parents as well as the patients need to have their minds freed of misinformation, of unfounded fears, of shame and a desire for secrecy. Accomplishment of this task for an older child and those about him—parents, playmates (and their parents), and school teachers—may require the integrated efforts of doctor, social therapist, and psychologist.

The children should, if possible, continue to attend school regularly, since activity of mind and body helps to prevent seizures and since natural association with other children is important, not only for progress in education, but for social training and emotional stability. A poised and sympathetic attitude on the part of the teacher, and appropriate explanations to the other pupils and their parents constitute essential aid to doctor and patient alike. The presence of a child having frequent petit mal or an occasional convulsion should not upset the school routine or emotions unduly. In fact both teacher and pupils should recognize that acquaintance with and appreciation of a person with some handicap is an important phase of education for life.

The social therapist, in addition to arrangements regarding special classes, summer camps, and colony care, has the task of explaining epilepsy to parents, school teachers, and the personnel of social agencies.

A book about epilepsy and its cousin, migraine [3], written for the lay reader, is given by the unit to parents and patients able to profit from it.

Another patient, Eddie B., an attractive 11-year-old, was doing excellent work in the fifth grade, but was nevertheless required by the school physician to withdraw because of his seizures. His mother forbade his leaving the house alone for the same reason. Of course, he lost his friends, for they did not understand why he never came out to play. He was thoroughly unhappy, and he expressed his frustration by teasing his parents and sisters.

The brain-wave test (electroencephalogram) given him at the clinic displayed irregularities of the waves consistent with his daily petit mal (a blank stare with brief unconsciousness) and his monthly convulsions. With daily use of medicine the convulsions ceased, and the petit mal seizures were of shorter duration. Nevertheless, the mother so dreaded a return of the attacks that she continued to treat Eddie as an invalid, and his apprehensive school teacher did not want him to return to school.

At this point, the clinic doctor, seeing with dismay that in spite of successful therapy the boy was as handicapped as ever, called in the social therapist. She talked with the school principal and with Eddie's teacher, and explained the benign nature of Eddie's illness, told her how to manage his attacks should they occur in school, and described his need for companionship and for normal social relationships. She explained again and again to Eddie's mother that her fear of attacks and of consequent embarrassment was not only unjustified but was interfering with Eddie's normal development.

The mother was then persuaded to let Eddie go to a summer camp. The counselors were given full details of his condition, and his fellow-campers paid little attention to the occasional short "black-outs" or to the medicine he took at mealtime. However, they resented the boy's tendency to shirk his share of the work and to avoid the hiking expeditions. These difficulties were gradually ironed out, and when he came home from camp his mother immediately recognized a change for the better. Eddie himself reassured her, saying, "Aw, Mom, what ya worrying about? I'm okay; I never even think about spells anymore." That fall he went back to school, and he worked and played well and was too busy to tease the other members of the family. By the end of the school year and after several more conferences with the social therapist, his mother had begun to believe Eddie's statement of the preceding autumn, "I'm okay!" The case is not closed, for his drug therapy must be supervised and his brain waves again recorded; but "so far, so good."

Cost of treatment

The subject of cost of treatment is a cause for thought. Quality treatment must be relatively expensive, no matter who pays the bill. But if it is successful, quality treatment in the long run is "dirt cheap." It must be remembered that there are two aspects of cost accounting—the amount spent by the family of the child attending the clinic and the cost of quality treatment above what the family spends.

As a part of her thesis for graduation from a school of social work in 1948, Emily Leone questioned the parents of 150 children to ascertain the amount of money the families had expended in visiting the clinic. The charges for the initial visit, of course, were higher than the charges for subsequent ones. To arrive at the cost of a representative visit, adjustment was made for the proportionate number of initial and return visits. The former numbered 288 and the latter 1,031—a total of 1,319.

A breakdown of the items of expense to the parents is as follows:

Transportation (including parents')	**$2.66**
Clinic fee (regular fee $3)	**2.94**
Parents' time lost from work	**1.17**
Medicine prescribed	**2.67**
Electroencephalogram	**1.57**
X-rays	**1.03**
Interim hospitalization	**.73**
Interim care by local doctor	**1.03**
	13.80

The estimated cost of treatment above what the patient paid was almost as much, $12.99. The estimated breakdown of the unit's expenditures was as follows:

Doctors' services	**$5.23**
Social service	**3.17**
Secretarial and technical help	**2.59**
Cost to hospital above clinic fee	**1.24**
Medicine, donated by drug houses	**.76**
	12.99

Since there were 1,319 visits during the year, the total amount expended was $18,202.20 by the parents and $17,133.81 by others. The combined total cost of a visit of $26.79 doubtless seems high. This appearance is due in part to the fact that certain costs usually ignored are included, such as the time lost from work and the contributed services of clinic physicians. Cost of travel is high because many patients come from a distance. Contrary to the usual custom, doctors assisting in the clinic receive pay for the time spent. Secretarial expense is heavy because of the need for much correspondence with referring doctors and the keeping of follow-up reports. Cost of research investigations are not included. More complete details of this study appear elsewhere [4].

Given experienced doctors and a first-class electroencephalographic laboratory, the epilepsy of 95 percent of patients can be diagnosed and treated in the out-patient department rather than in the wards, with great saving to both patient and hospital. Although, as was stated before, quality treatment is never cheap, the size of the epilepsy bill (for the medical and social relief effected) is minute when compared with the cost of treating conditions such as cerebral palsy and polio.

Only patients in families with limited incomes may attend our clinic. Hence, this enterprise could not function without added aid. Grants for research have come from the Rockefeller Foundation and from the Public Health Service, Federal Security Agency. Much of the money for the conduct of clinics is supplied by the Bay State Society for the Crippled and Handicapped, a private organization that sponsors the sale of Easter Seals. The National Society for Crippled Children and Adults has adopted services for epileptics as one of its major projects, so that State chapters of this organization besides the Massachusetts one presumably will be interested in clinics for the epileptic.

However, in comparison with other handicapping conditions, epilepsy has been neglected, and in this wide field of need possible duplication of aid is no problem. The National Epilepsy League, with headquarters at 130 North Wells Street, Chicago, aids in planning and in the education of the public. Help with problems of medical organization and conduct is also available through the American League Against Epilepsy, an organization of doctors. The secretary of the League is Dr. J. K. Merlis, National Veterans Epilepsy Center, Cushing Veterans' Administration Hospital, Framingham, Mass.

The handicap caused by epilepsy is as much social as physical, for the seizures may interfere with the victim's education and with his future employment. Therefore, epilepsy, although a hopeful disorder, is a crippling condition of large proportions. Investment of effort and money in early diagnosis and treatment yields large returns.

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"DEAR MR. SUPERINTENDENT:"

Six adolescent boys suggest ways of improving the institutions they used to live in

MARTIN GULA, Group Care Consultant, Division of Social Services, Children's Bureau

I WAS TALKING at the dinner table with six boys ranging in age from 16 to 20. Three were going to high school; the other three were working at various jobs. All had been living in various children's institutions up to a few months before, and were now living in a big city at a boys' residence, which I was managing.

We talked about institutions—about the food, about the rules and restrictions, the cottage parents, and the superintendents. I mentioned the possibility of my directing a children's institution, and my hopes of developing a good one. When I spoke of my intention to ask people for suggestions to help make my institution the best possible one, Freddie interrupted with the question, "Why don't you ask *us?*"

I did. I asked the question: "If your superintendent had asked you to name the 10 things you would want most in your own institution, what would you have asked for?"

The boys got together at a table. Freddie was the "secretary," and wrote as the others talked:

"*Dear Mr. Superintendent:*

"*If you had ever asked me, I would have liked to say,* "*Please may I have—*

"*1. A bed of my own.*

"*2. Not too many boys in the same room with me. I never feel alone. And not too many big boys who are bullies and get away with it. I like to be alone sometimes. And I like to be with my buddy sometimes. But you always made us do everything in bunches.*

"*3. A few shelves nearby, where I could putter with my airplane or stamp book before I went to bed.*

"*4. A closet nearby where my own clothes could be kept.*

"*5. A cottage mother who loves me like a mother. I don't mind if she's tough, if she's fair. And not too old so she can't have fun with us once in a while. And she should look for the best in us kids, not the worst all the time. And she should have snacks with us and laugh with us like Mrs. X used to do.*

"*She should like our parents even if they don't come to visit, or only come to give us things. And she should have some time every day to be alone with me, even if only for 5 minutes, please.*

"*6. A cottage father who likes us kids, not a guy who's busy fixing his car all the time and won't even let us stand around to see how he does it.*

"*He should take us out once in a while to something special like a college football game or a hobby show or something. Who doesn't mind if we yell sometimes and break a chair. And he should be like old Mr. Y. He was old, but he always had fun with us and he was fair and he never had much trouble with us kids like the other cottage fathers.*

"*And he shouldn't complain about the case workers and the superintendent and the food.*

"*7. Nice meals like we know kids have in their own homes. In my institution, whenever we saw beef stew we knew it was Wednesday. And we were always right. The girls used to say that the cook only knew how to make seven things, one for each day of the week.*

"*And we don't think it's fair for the grown-ups to eat different things—except coffee.*

"*And why weren't the girls allowed to sit at our table once in a while, sort of mixed up?*

"*8. A chance to be with the girls and learn how to dance and have fun. Now we go to the 'Y,' and all we do is stand by the door.*

"*9. A little workshop that could be open most of the time, where we could make things that we wanted to make—or a place to make a model railroad, like Georgie, here, says he made in his home. Or a place to have magic shows for money—selling tickets, and everything. And sometimes a chance to go out with the other kids in town and not feel we were different all the time.*

"*And sometimes a chance to go to town alone and feel I was like everyone else walking around. And maybe go to the Main Street movie instead of our movie in the auditorium all the time. And join the 'Y' hobby club in town.*

"*10. And, last—you told us we could only write the first 10 things—a better chance to find out about our folks when we're in institutions. When they don't come and don't write and don't call, we get worried. Especially the little kids and the new kids.*

"*And that's what was good about the social worker. She saw us once in a while and sometimes we could find out things.*

"*Yours truly,*
"*Freddie, Leo, Lefty,*
Georgie, Jackie, Bill"

Would these ideas be typical of the ideas of the 200,000 youngsters who are now in children's institutions of all types in the United States?

Mr. Superintendent, you are undoubtedly looking for ways to help the child in your institution grow into a socially responsible citizen and parent. You probably read social-work journals, attend institutes, and exchange experiences with other institutional executives. But do you ever ask for the ideas of those who are most concerned—the boys and girls themselves?

If you have received helpful suggestions from your boys and girls or "alumni," would you care to send them to me, care of the Children's Bureau, Federal Security Agency, Washington 25, D. C.? Perhaps, later, we can present an interesting supplement to these 10 points mentioned by the boys who wrote: "Dear Mr. Superintendent."

WHEN BOYS AND GIRLS LEAVE SCHOOL FOR WORK

Bureau of Labor Standards Reports on Study of Out-of-School Youth

ELIZABETH S. JOHNSON, Chief, Division of Child Labor and Youth Employment, Bureau of Labor Standards, U. S. Department of Labor

LEAVING SCHOOL for work is a pivotal point in the life of a boy or girl. And in making this transition young people face important personal and social problems. Some of these problems are described in the words of the boys and girls themselves in a bulletin called Hunting a Career; a study of out-of-school youth in Louisville, Ky., published by the Department of Labor's Bureau of Labor Standards. (A preview of this report was published in THE CHILD in October 1948.)

The community likewise faces problems with regard to these boys and girls, for society has a stake in seeing that each one of its members, as he grows up, has a good start. For society becomes strong and stable only as its individual young citizens can, and do, adjust satisfactorily to their adult responsibilities.

To get a close-up view of such problems, representatives of the Bureau of Labor Standards in the spring of 1947 interviewed 524 out-of-school boys and girls in Louisville, Ky.—chosen as a representative American city—asking them about their experiences in finding and keeping jobs. The young people, who were selected at random, ranged in age from 14 through 19 years. The Bureau representatives also interviewed employers, union officials, staff members of community agencies, school and work-permit officials, and State labor-department officials, to find out about the attitudes of adults concerned in the young people's job problems.

Although the general level of employment was high in Louisville and in the country as a whole at the time of the study, 177 of the 524 boys and girls were unemployed when interviewed. In general, the proportion without jobs decreased as age increased. Many of the unemployed had been jobless for months, and 31 had never had a job. Children who had dropped out of school in the eighth grade or earlier appeared to have much greater difficulty in finding and holding jobs than did those with a better educational background. There was a great deal of shifting from job to job.

Two-fifths of the 194 out-of-school youth who were 18 or 19 years of age when interviewed were high-school graduates, and most of the others in this age group had completed at least the eighth or ninth grade.

The educational level was lower among the younger groups. Slightly less than half of the 217 young people who were 16 or 17 years of age had completed as much as the ninth grade. Four-fifths of the 113 children who were 14 or 15 years of age when they were interviewed had dropped out of school without completing more than the eighth grade, and nearly one-third had left without completing more than the seventh.

Not ready for the working world

The problems of these young Louisville people, who were out of school and in the labor market, seemed to fall into two groups. First, when the boys and girls tried to fit themselves into jobs, they found a discrepancy between their personal equipment and the equipment that they needed for employment as young adults. Secondly, they found that a gap lay between themselves as individuals and the community with its various services.

These situations were for the most part unrecognized by the young people themselves. However, they felt the effects—the frustrations—of not being able to find jobs, of recurrent unemployment between jobs, of decreasing confidence in their ability to make their way alone, of realizing that in leaving school too soon they had taken the wrong turn.

Some of the boys and girls, however, liked their jobs. As would be expected, their attitudes varied. Among 493 young people interviewed who had held jobs of at least 15 hours a week since leaving school, 162 were described by the interviewer as "highly satisfied," and another 202 as "moderately satisfied," 84 were described as "moderately dissatisfied," and 45 as "acutely dissatisfied." An example of each category follows:

A boy whose work history placed him in the category of "highly satisfied" was Bill, who was employed as a baker's helper in a cafeteria. Bill's father was a baker and had encouraged the boy in his trade. The boy expressed great satisfaction with this work and planned to attend a school for bakers in Chicago to acquire more skill in his chosen trade. Bill's enthusiasm seemed to grow out of his knowledge of this type of work from his own experience, his successful start in it, and his family's approval.

Melva, an attractive 18-year-old girl, was described by the interviewer as "moderately satisfied." Melva graduated from high school and took a full-time job in a large department store, where she had worked after school and during vacations. Melva was a complaint clerk, and she enjoyed dealing with people but felt this was a dead-end job. Melva did not care for typing or shorthand, and although she would like to be a model saw no way to accomplish this dream. Melva was interested in her work, but her satisfaction in it is not too great because she saw it had no future, vocationally or financially, and she did not have the financial backing to make it possible for her to acquire further education and training.

"Moderately dissatisfied" was the notation the interviewer placed on Clara's story. Clara was a 19-year-old secretary in an insurance company. "Until I have a chance to try designing clothes," said Clara, "I'll never be satisfied." Clara said of the work in her clerical job, "It's not too boring." She liked the working conditions and pay. With her mother's encouragement, however, she was planning to enroll at the university for a course that would help her toward a career in her chosen field of designing clothes.

John Edward, a Negro youth of 16, who said he loathed the job from which he had just been laid off, was obviously "acutely dissatisfied." That job had been as a section hand on a railroad. He disliked any work that would keep him outdoors in all kinds of weather. He seemed to have a genuine interest in machinery, and a desire to work with it, but as he had only an eighth-grade education and no plans for obtaining further training, there seemed to be small prospect that he would be able to get a mechanical job.

The picture given by this report of the facts about youth employment and unemployment in one community indicates the need for over-all planning for their needs in every community, and it highlights specific approaches to the solution of some of the difficulties the young people encountered—not only in one locality, but in many.

The lack of personal equipment for a venture into the working world among many of the young people showed up even among the older boys and girls, but was most glaring among the 14- and 15-year-olds.

The immaturity of boys and girls out of school at 14 and 15 years, their poor preparation for work, and their difficulty in finding employment of any kind, point up with renewed emphasis the importance of continued schooling, at least to the age of 16, even though the number of out-of-school boys and girls in the labor market constituted no more than 2 percent of the 14- and 15-year-olds in Louisville. The fact that there were an estimated 303 boys and girls 14 or 15 years of age out of school in a city of this size shows the great need for legislation to support school attendance for them through placing a 16-year minimum age on all employment during school hours.

Society has a special responsibility toward any child who is pulled away from school by financial need—whether in the form of pressure to contribute to the basic family support or in the form of inability to meet the expenses incidental to attending school. Adequate funds for student aid from some source are needed, in addition to programs of public assistance and social security, which can scarcely be expected to care for all needs where financial difficulties are about to pull a boy or girl out of school.

An effective student-aid program, however, requires more than money. It must be administered so as to preserve and not break down the young person's self-respect. The sensitivity of adolescents is recognized in a general way. But what adults do not always remember is that unless care is taken to respect this sensitivity, the best-intentioned assistance may be rejected.

For young people in school, the school itself is the natural point of contact with community resources. For those out of school what are the points of contact with the community's services for guidance and placement?

First is the public employment office. The young person knows he wants a job, and if he thinks the employment service can help him he is likely to turn to it. He may be vaguely or wholly unaware of his need for guidance; yet this is really his greatest need.

Paving the way into the public employment office is the first need. Give-and-take between school and public employment office, exchanging labor-market information and knowledge about individuals and cooperating in placing in-school youth in part-time work, helps to build a strong foundation of confidence in the public employment office on the part of the boy or girl leaving school.

The channels for vocational guidance to out-of-school youth are many. Services from the schools and from specialized private agencies should be drawn on so that each young person receives the best the community can offer him.

The services of social agencies also are indispensable in seeking to bridge the gap between school and work. The difficulties experienced by boys and girls in making a satisfactory adjustment in school or in the transition from school to work very often are the result of progressive social and personal maladjustments in the course of their growing up—in their home, in the school, and in the community. And any maladjustments that develop are likely to hinder them also in their working relations.

Reaching the child, as he is growing up, with needed mental-health services, remedying his health defects, and providing vocational rehabilitation to the handicapped can prevent many seri-

A young person who has the help of a skilled counselor need not drift into an unsuitable job.

CHOOSING
YOUR
LIFE WORK

ous problems from developing. When needed services are deferred until the trouble becomes so acute that the child drops out of school or quits his job, irreplaceable waste of human values results.

The schools and all other agencies and professional workers coming into contact with young workers who have job and vocational problems need to be thoroughly acquainted with the other services available. A web of free communication among all these agencies is desirable, so that a young person known to one staff worker can be put in touch with any appropriate services that are available elsewhere in the community.

In sizing up the employment needs of young people in a community and the adequacy of its services for meeting their needs, it is important to look particularly to youth from Negro or other minority groups and to the children in low-income families. The problems of these young people are those of all young people, but they may be more acute. It requires insight and genuine interest, first, to find out what their needs are, and second, to reach them as effectively with community services as we reach those in more favored situations. Children living in the alleys or on the wrong side of the tracks, children belonging to minority groups, are very often the ones who are most diffident in seeking help, most inarticulate in expressing their needs. If they are to be reached, the community must go more than half way. On the other hand, when a young person finds his needs recognized and meets with simple friendly service on his own level of understanding, he is quick to appreciate it. The word spreads. Here, then, may lie one key to finding those elusive young people who, needing help, fail to seek it.

The bulletin offers one suggestion from which any citizen may profit. "To get the most from this report," it says, "substitute for 'Louisville,' wherever it appears, the name of your own town or city, and then try to judge how many of the findings apply, and what can and should be done to improve employment safeguards and educational and employment opportunities for the young people who live there."

Homemaker Service Helps a Motherless Family
(part 2)

MARJORIE H. BOGGS, *Family Service Association of Cleveland*

Editor's note: *This is the second part of an article that was begun in our May issue. (We shall be glad to send a copy of the May CHILD to any reader who missed part 1.)*

In part 1 of the article, Miss Boggs defined "long-time" homemaker service, which is sometimes offered by a social agency to a family when the mother is away from home permanently or indefinitely. In this second part she continues her description of such service as given to a family of six children whose mother had been killed in an accident.

During the year since the mother's death the grandfather had looked after the children while the father, Mr. B, worked. But neighbors complained to the police that the children needed better care. That complaint brought the father to a family agency for help. In the interviews that followed, Mr. B became enthusiastic about trying homemaker service.

The children were Ann, 14; Martha, 8; Bobby, 7; Jack, 5; Laddie, 3; and Freddy, not quite 2. Martha and the three youngest children presented no difficulties. Ann was Mrs. B's daughter, adopted by Mr. B, and did much to take her mother's place with the other children. Bobby, 7, was the family problem. His mother's favorite, he was greatly affected by her sudden death.

Mr. B was a reticent, hard-working man, deeply interested in his children. He seemed to be under a great strain and had physical ailments that were probably due to emotional causes of long standing. The grandfather had evidently been unable to keep up with six lively children; they showed a great lack of training. Nevertheless he seemed reluctant to give up his duties in the home.

The homemaker started her work feeling that the family needed her and welcomed her. On her visit to the home to meet everybody, she and Mr. B clicked immediately. Except for Bobby and the baby, the children had been outwardly responsive, and the homemaker felt confident that she could get along with the father and children. Grandpa had stayed away from the home during this visit.

From the beginning the homemaker had only praise for Mr. B. She saw him as a good father. He would come home tired, yet patiently let three children at a time climb over him. He had always done the evening cooking and seemed to want to continue. The homemaker realized, she said, she wasn't supposed to "try to make over fathers," but she did wish he'd take things easier.

For a few weeks the homemaker maintained a reserved tolerance for Grandpa. He was underfoot and bossed the children unwisely, but she knew she should step in only when it was important.

With Ann, the homemaker succeeded from the start. She deferred to Ann in household matters, and seemed to make her feel that they were a team in bringing up the children. The homemaker admitted to some pangs of jealousy when Freddy continued to go to Ann in preference to her when Ann was at home. She realized that Ann was competing with her by getting him to do so. The homemaker soon began telling the case worker that the mother, Mrs. B, must have been a very bad housekeeper. Ann was willing to help but hadn't been taught to do anything right. The homemaker never belittled the mother to Ann, but instead would say, "I have always done it this way." Ann seemed to want to learn. The case worker helped both the father and the homemaker to encourage Ann's interests that were normal to an adolescent girl without making her feel pushed out.

After a few months the homemaker suddenly told the case worker that as much as she liked Mr. B and the children, she didn't know how much longer she could stay. Grandpa had been more of a strain on her than she had revealed. He was getting worse. He was critical of everything she and Ann did, and his careless habits made more work for everyone. She hadn't told Mr. B how she felt; she couldn't bear to add to his burdens. She thought he would be relieved if the agency would make some other arrangement for Grandpa. That might not be easy, the case worker told her, because the grandfather had always been part of the family. Nevertheless, she would talk about it with both men, without emphasizing the homemaker's complaint.

When the case worker started to talk to Mr. B, fear that the homemaker might leave because of Grandpa threw him into a near panic. Because of the homemaker he had had more peace of mind than he had known for some time. He knew the old man could be trying—he was trying to him, too, at times. Grandpa hadn't contributed financially as he had promised, but he did buy the kids things and sometimes bought food, so he was really paying, on his own terms. Mr. B could overlook Grandpa's annoying behavior, and he just couldn't put out of his home a sick old man who had helped him when he needed help. He hoped the homemaker could see it his way.

Mr. B then revealed great anxiety lest he lose his job, because the company was beginning to lay off men. Then, if he couldn't pay what he'd agreed, would we withdraw the homemaker? He had worried about that in spite of our original explanation of why the agency provided homemakers. His physical ailments were getting worse, he said, and his doctor told him they were from worry. And now this trouble about Grandpa! Could the case worker do anything?

The depth of Mr. B's feeling of dependency and his neurotic pattern of reacting to pressure can be seen here clearly. The case worker had been aware of them in her talks with him but had found no way to break through his defenses to help him. That was because both he and the homemaker saw all as going well.

Talking it over with Grandpa

Soon the case worker, chatting casually with Grandpa, asked him if he would come to the office. He had long been carrying a lot of responsibility and she would like to get his slant on things. He was delighted to come.

At the interview a simple question about how he was feeling brought out his intense fear of going blind, of having a heart attack, of not having enough savings for his old age. He knew he needed new glasses but was afraid to go to a doctor lest his fear of blindness be confirmed.

Indirectly the case worker was able to make him feel that he had done his share for the children, that he meant a great deal to them but now he should take care of himself and have some pleasure. She said he had done wonders in helping the homemaker get established.

Why didn't he turn over the daily care of the children to her, merely backing up her discipline? Then he wouldn't have so much on his mind. Instead of waiting on the others he should expect them to do a little waiting on him. Pleased, he thought he would. First he might get himself to the eye doctor.

He spoke well of the homemaker, seeming unaware of her criticism.

A homemaker may change her mind

The homemaker's disapproval soon turned to sympathy. She told the case worker that Grandpa had come home with the news that the worker wanted him to see a doctor so he wouldn't go blind. He had spoken of all his fears, saying that, because of them, he was greatly relieved to have her caring for his dead daughter's children. His praise surprised her. Now she thought it might help if she made a little fuss over Grandpa, maybe by catering to his food likes. The homemaker still sees Grandpa as someone who needs her help and she can use with him the ingenuity she is successfully using with the children.

The current crisis is Mr. B's hospitalization. When a lay-off became imminent he suddenly, while on duty, became partially paralyzed and was taken to a hospital. The paralysis soon cleared, but he is being held in the hospital for observation to rule out any possible physical cause.

Let us consider now the three members of the B family most in need of help and the roles of homemaker and case worker, respectively, in relation to them.

Mr. B is showing symptoms of internal struggle that may lead to invalidism and inability to maintain a home for his children. Up to this point he has hurt himself primarily. The homemaker still sees him as an adequate father and it is best that she continue to do so. That he will need help for himself is evident. Perhaps his most recent break-down—the paralysis—will enable him to accept this help. If the case worker can get him to talk out some of his worries, resentments, and fears, he may experience enough release from tension to be able to carry on as he has in the past.

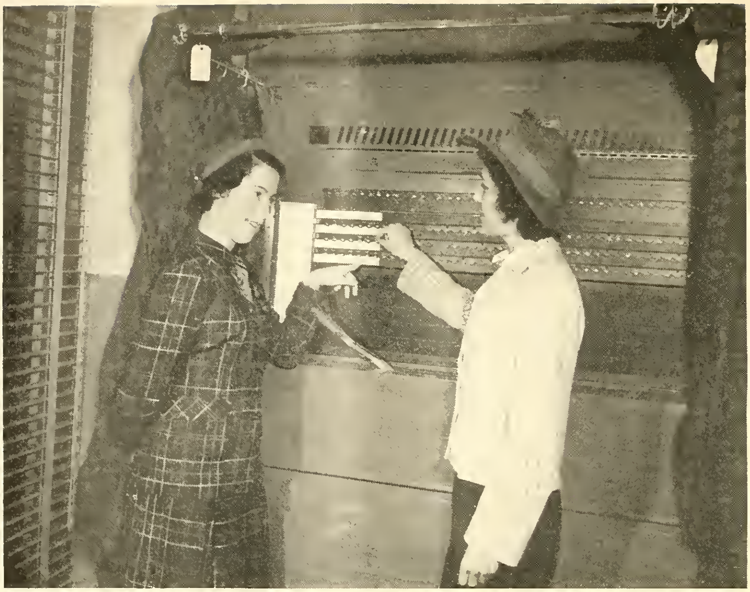
Bobby has shown marked improvement in the 6 months the homemaker has been in the home. If she can remain a steady figure in his life for long enough, he may recover from his hurt with only slight scars. Or he may at some point need more intensive help from the case worker. His night terrors and his symptoms of compulsion and withdrawal, although lessening, indicate difficulty beyond what is natural to his age and to his situation.

Ann seems to be growing up normally without direct help other than what she is getting from the homemaker. An agency ordinarily has qualms about placing a homemaker in a family where an adolescent girl has been playing the role of mother. We might well have had extra qualms in Ann's case. We did not know how she felt about her mother, how she was affected by the facts of her birth and the absence of a father, and by the slightness of the contact she had had with her mother during her first 5 years. Perhaps the continuous presence of her grandparents had provided the feeling of security parents usually give their children.

What is ahead for Ann?

Ann is barely 14 and so far is centering her outside interests largely in girl friends. We know that at the period of puberty a girl is looking for a feminine object with whom to identify herself. So far the homemaker seems to be meeting this need for Ann. We cannot be certain that there will be no adolescent tempests for we know little as yet of Ann's inner feelings.

From this brief sketch of one family situation the importance of the case worker's role can readily be seen. It is also apparent that the case worker could have accomplished little without a homemaker endowed with a capacity for mothering, for seeing the members of the family objectively and in perspective, and for teamwork. And the case worker and the homemaker need to work together within the framework of the agency. Thus they can make the service of maximum good to the various members of the family.



YOUTH DEMONSTRATES "LOYAL CITIZENS IN ACTION"

LUCILE ELLISON *Assistant Secretary, National Commission for the Defense of Democracy Through Education, National Education Association*

FROM Hawaii, Alaska, Puerto Rico, from the 48 States, they came to Washington, a thousand strong, to the Fifth National Conference on Citizenship, May 22–24, 1950. The 500 organizations they represented—religious, veterans', educational, civic, youth, and other organizations—cover nearly every phase of American life and embrace almost the entire 150,000,000 population of our country.

Over a period of 4 years planning committees, called together by the National Education Association and the United States Department of Justice, joint sponsors of the conferences, had been emphatic in urging that youth should have a strong place in the program. This year's committee recommendations said:

"Youth should have a full share in the conference—'a good spot on the program' with emphasis on how to develop habits of good citizenship."

"Though youth participation has increased, it has not grown enough. A 'youth in the spotlight' as a main session speaker . . ."

"Agreement: . . . to obtain a better representation of youth on the planning committee as well as at the conference."

To the 1950 conference, the young people added the vigor and freshness that planning committees had anticipated.

Youth delegates appeared for an orientation session the day before the conference began. Before the opening general session, they chatted with organization and Government leaders at an informal coffee hour. As a part of the delegate body, they participated in "buzz sessions" and discussion groups.

At a general luncheon youth presented the discussion topic, "Improving Citizenship Through Our Organizations." Five teen-agers who had won national honors for their work for democracy discussed such questions as: To what extent do our members participate in our organizations? Are we educating for democracy? What percentage of members take part in the election of officers? To what extent are both sides of controversial questions considered? How can organizations with similar aims and views work together?

Who are they?

The five came from widely varying backgrounds and localities:

James H. Grant, 19, Orlando, Fla., winner of the 1948 national oratorical contest sponsored by the American Legion, a former governor of the Florida Boys' State, now a student at Emory University, Atlanta.

Gloria Chomiak, 17, Wilmington, Del., a high-school student, one of four winners of the 1949–50 "Voice of Democracy" contest, in which more than 28,000 high schools participated. Miss Chomiak was born on a farm in Alberta, Canada, of a family of Ukrainian descent and has lived in Wilmington only for the last 3 years.

Rogers Fike, 20, Eglon, W. Va., first vice president of the Future Farmers of America and winner of its national speaking contest. He also has been a president of his local and State FFA associations and active in other civic groups. Since graduating from high school, he has been in charge of the operation of a 125-acre general crop and livestock farm owned by his parents, Mr. and Mrs. John T. Fike.

Rhonwyn Lowry, 19, Moultrie, Ga., student at the University of Georgia, twice a State project winner in the 4–H Clubs, second-place winner in the national speaking contest sponsored by the Farm Bureau Federation and in the National Rural Youth Talkfest, and chosen as one of the outstanding members of the 4–H Clubs during national 4–H Club week.

Immanuel Wallerstein, 19, New York City, a senior at Columbia University, a member of the young-adult council of the Social Welfare Assembly, and a member of the national executive committee of the United World Federalists and of the New York State Committee.

Young people help in planning

Youth was featured elsewhere in the 3-day program. On the planning committee and among the group leaders were nearly a dozen widely representative teen-agers. At each of the meal functions, high-school choruses of from 40 to 70 members sang. The Boy Governor of the New Jersey YMCA Model Legislature, William L. Bradford, gave the invocation at the Tuesday luncheon.

However, possibly the most significant contribution youth made to the Fifth National Conference on Citizenship was in terms of mechanics and details which they carried and directed. One conference leader said: "By far, the most thrilling part of the conference is the generous spirit of the many people who work in it. It is a time of stress just a little like war or a fire. There are some spectacles to make one ashamed of human nature, but there are many more examples of gallantry and pure heroism."

Everybody pitches in and helps

For days, voluntary workers sorted, tabulated, assigned. Paid staff worked evenings and weekends at much personal sacrifice. Bob Hamilton, a University of Maryland student and the Boy Scout representative on the planning committee, gave his leisure hours for weeks before the conference.

Often by accident, not at first hand, conference leaders learned of those personal sacrifices by youths—of the "I'll see it through" in regard to the many details that go into a conference where "everybody counts one and everybody helps."

Representatives from 50 organizations had helped to choose the theme. "We want something practical; stay away from generalities," the committee said. "We'd like to talk about intelligent voting, every citizen voting.

"But," they added, "while the greater emphasis of the conference should be on practical citizenship, it must also not fail to affirm 'the growing faith that one is a good citizen every day of one's life.' As long as voting is an end rather than a means, and citizenship is 'a second-hand tradition instead of a first-hand experience,' our emphasis is in error."

Here is our theme

The theme that evolved from the committee was "Loyal Citizens in Action: You ARE Your Government."

Youth at the 1950 National Conference on Citizenship demonstrated loyal citizenship in action, while at the same time they learned techniques that would help them to *be* a better government.

CONGENITAL SYPHILIS

(Continued from page 184)

prevalence of syphilis, mass testing of children under 15 years of age has found roughly 3 to 13 percent positive or doubtful reactions among Negro children and about 1 to 4 percent among white children. In one such area about 2 percent of the blood tests given to Negro children resulted in finding previously untreated syphilis, and in another area, 4 percent. These data would seem to warrant mass blood testing of school children in areas of high prevalence. It would be desirable and practical if such blood testing were part of a more inclusive health screening procedure that would include tests for visual and hearing defects, anemia, and other physical handicaps.

Should we screen school children?

School-health services of some kind are provided in almost half the counties of the United States. Whether these services are the responsibility of health or of education authorities, the maternal and child-health division of the health department is in a position to exert considerable influence on screening procedures for children of school age.

Summarizing briefly:

In almost any State the maternal and child-health program and the venereal-disease-control program can assist each other in this joint program against congenital syphilis.

The investigation of sex contacts and of family contacts and the presentation to the general public of the facts involved would be handled best within the venereal-disease-control program.

The maternal and child-health program is in a position to pass the word along to mothers, to professional workers, and to hospitals and other agencies that care for mothers; to encourage blood testing as a routine part of prenatal care; to exert a certain amount of influence on hospitals; to work with midwives; and to work with school health services.

Both programs can extend the message to specific population groups. Both can reach a large percentage of parents directly through bulletins and pamphlets and through parent-teacher associations and other parent groups.

Both the Children's Bureau and the Division of Venereal Disease of the Public Health Service are willing to devote every available channel of communication to telling the public or groups within the population the story of congenital syphilis.

To us a child with congenital syphilis is a child with a general disease—a child who is likely to need special help to achieve optimum physical and emotional health even when his syphilis is cured. We suggest, therefore, that venereal-disease personnel call on the maternal and child-health services for assistance in obtaining the pediatric and auxiliary services—nursing, medical-social, and nutritional—that these children may need.

These statements, quite frankly, are a plea for mutual assistance and action in the control of congenital syphilis rather than a blueprint for action.

We do not know precisely what form this assistance might take in the various States; but we are convinced that, if Federal, State, and local programs merge both venereal-disease control and maternal and child-health activities into a single program for immediate action in controlling congenital syphilis, there will be a sharp downward trend in congenital syphilis in the not too distant future.

Reprints in about 4 weeks

• FOR YOUR BOOKSHELF

JUVENILE COURT LAWS IN FOREIGN COUNTRIES, by Anna Kalet Smith, Federal Security Agency, Children's Bureau Publication No. 328, 1949, Washington. 67 pp. 20 cents. Superintendent of Documents, Government Printing Office, Washington 25, D. C. Very limited supply of free copies available from the Children's Bureau.

In response to the widespread interest in juvenile courts, this bulletin summarizes laws concerning such courts in each of the 60 independent countries and other territories where such courts are known to exist, as well as laws on procedures similar to those of juvenile courts.

Discussion is limited to the text of the laws because virtually no information on their administration is available. No attempt has been made to evaluate the laws or to study them in detail.

THE CRY AND THE COVENANT, by Morton Thompson. Doubleday & Co., Garden City, N. Y., 1949. 469 pp. $3.50.

This is the intensely dramatic story of the life of Ignaz Semmelweis, the Hungarian physician who was the first man in Europe to recognize the contagious nature of childbirth infection, and who proved how it could be prevented through rigid cleanliness of the attendants and of the bedclothes and other hospital equipment.

The book gives a detailed and vivid account of the practice of obstetrics in Europe a century ago, when, in some European hospitals, 100 percent of the maternity patients died, on to the final achievement—*no* deaths from childbirth infection during a whole year in a hospital service under the direction of Semmelweis.

The bitter attacks on Semmelweis by the medical profession in Europe were even worse than those made on our own Oliver Wendell Holmes, who, in America, 4 years before the first Semmelweis report, declared childbirth infection to be contagious and preventable.

Edwin F. Daily, M. D.

AMERICA'S HEALTH, A REPORT TO THE NATION, by the National Health Assembly. Official report. Harper & Bros. New York, 1949. 395 pp. $4.50.

This extremely valuable book gives a concise summary of the deliberations of the National Health Assembly, which convened in May 1948, at Washington, D. C., at the request of the Federal Security Administrator. Both the pre-Assembly planning and the Assembly sessions reflected the care that was taken to secure eminent professional and lay representation and to promote democratic participation. The Assembly, comprising some 800 representatives of professional and lay groups, was divided into 14 sections; each chapter in the book embodies the findings and recommendations of one of these sections.

The first chapter, "What Is the Nation's Need for Health and Medical Personnel?" illustrates the approach. This chapter presents estimates of the number of physicians, of nurses, and of dentists, that will be needed by the year 1960.

The forecasts of the number of physicians needed, for example, are calculated on three different premises: That there will be enough physicians (1) to maintain the physician-population ratio as it was in the Nation as a whole in 1940; (2) to reach the ratio that was attained by the 12 best States in 1940; (3) to provide adequate medical care on the basis of the Lee-Jones estimates. (These estimates are given in The Fundamentals of Good Medical Care, by Roger I. Lee and Lewis Webster Jones. University of Chicago Press, 1933.)

The increase in student enrollment that will be necessary to fulfill these estimates, as well as the estimated 1960 needs for nurses and dentists, is presented, together with a discussion of the financial problems of the schools.

Other section reports are concerned with hospitals and health centers, local health units, chronic disease and the aging process, maternal and child health, rural health, and research. The remaining chapters take up medical care, rehabilitation, dental health, mental health, nutrition, environmental sanitation, and international cooperation in health.

The subject matter is excellent in quality, and the editorial staff has integrated it into a well-knit and readable book. This single volume can be used as a reference for facts on the current status of the Nation's needs in the various health fields, for recognition of important accomplishments as well as major problems, and for specific and practical suggestions for accomplishment in the next 10 years.

Barbara B. Hodges
Paul Harper, M. D.

Reprints Available

A limited quantity of each of the following items, reprinted by the Children's Bureau from sources outside the Bureau, is available for distribution. Single copies may be had without charge.

Dental Services of the Children's Bureau. By John T. Fulton, D. D. S. *Journal of the American Dental Association*, June 1949.

Regulations for Maternal and Child Health and Crippled Children's Program. *Federal Register*, June 28, 1949.

School Health Services; a report from the American Academy of Pediatrics Study of Child Health Services. By John P. Hubbard, M. D., Katherine Bain, M. D., and Maryland Y. Pennell. *American Journal of Public Health*, June 1949.

Should Mothers Work? By Irene M. Josselyn, M. D., and Ruth Schley Goldman. *Social Service Review*, March 1949.

Special Report From the Committee for the Study of Congenital Malformations, of the American Academy of Pediatrics. *Pediatrics, Journal of the American Academy of Pediatrics*, February 1949.

Visitors Are Welcome on the Pediatric Ward. By Marion Stevens, R. N. *American Journal of Nursing*, April 1949.

GOING TO CAMP, by Helen L. Beck. Stephen Daye Press, New York, 1950. 163 pp. $1.95.

This is an earthy, exciting preview of what a child may expect in camp and from camping. Written in language familiar to the grade-school youngster, the book has value that extends beyond the camper to any person who is preparing a child for camp—the counselor, the camp director, the parent, or the social worker. Having personally experienced each of these roles, this reviewer warmly recommends "Going to Camp" as a "must" for children, and for all adults associated with camping experiences for children.

The unusual strength of the book lies not only in its thorough understanding of children's feelings before going to camp, in camp, and returning home, but also in conveying words of wisdom directly to the individual youngster, regardless of age or specific psychological readiness for group living away from mother and father.

Another strength lies in Max Barsis' humorous black-and-white illustrations. Every illustration in the book is a significant story in itself.

Martin Gula

• IN THE NEWS

U. N. Children's Fund Reviews Its Two Years of Aid to Yugoslavia

Reviewing its activities in Yugoslavia, the United Nations International Children's Emergency Fund (UNICEF) has reported spending more than $10,203,000 to provide supplementary food, raw materials, medical protection, and advance training of child-care personnel for needy children and mothers of that Balkan country since March 1948.

In addition, UNICEF's 26-nation executive board has allocated $1,683,900 for aid in Yugoslavia in 1950.

Most of the aid has been in the form of supplementary meals, reaching some 600,000 children and mothers, UNICEF officials said. Besides food, UNICEF is also providing raw leather for shoes and raw wool and cotton for processing by the Government of Yugoslavia in urgently needed clothing, sheets, and blankets.

In the field of medical protection, more than 4,500,000 children are being tested for tuberculosis, and those found free of infection are being vaccinated with the anti-TB serum known as BCG. This program is part of a world-wide drive conducted by UNICEF, together with the Scandinavian Red Cross Societies and the World Health Organization.

UNICEF is also working with Yugoslavia on a campaign against syphilis, under which the Committee of Public Health of Yugoslavia receives penicillin from the Children's Fund. The Committee is then responsible for the actual conduct of the campaign.

Another aspect of UNICEF's help to Yugoslavia includes provision of scholarships to meet the shortage of trained child-health and child-welfare specialists. So far, four physicians and four nurses have gone to France for 4 months' training each, eight physicians to Switzerland, five to Sweden, and four physicians and one nurse to England.

Maryland Sets 16-Year Minimum Age for Employment

Maryland has become the twenty-third State to adopt a basic minimum-age standard of 16 years, under a new child labor law, effective June 1, 1950.

Under the new law, no child under 16 may work in factories or in mechanical or processing occupations at any time. In all other occupations a 16-year minimum age applies for work during school hours, with a 14-year minimum for work outside school hours and during vacations except in farm work and domestic service.

Employment certificates are now required for minors under 18, and a 40-hour week replaces the former 48-hour week for children under 16. The coverage of the night-work prohibition is extended, and combined hours of school and work are regulated.

X-Ray Shoe-Fitting Machine May Harm a Child

Children are more likely to be harmed than adults by X-ray shoe-fitting machines, the Public Health Service warns.

If the machine is so constructed as to allow radiation to leak into the surrounding area, or when the machine is out of adjustment, or if the feet of the person being fitted are exposed to radiation a number of times in the course of fittings, the use of an X-ray fitting machine is almost certain to be harmful. This is especially true when an X-ray machine is used for fitting shoes on a child, for rapidly growing tissue is especially susceptible to damage from radiation.

The need for examination by X-ray in the fitting of shoes—except, possibly in cases of malformation—has not been proved, says the Public Health Service, and in cases of malformation it is assumed that medical advice would be sought.

— —

"The children are worth while. Nothing on earth is more worth while than they. They are the incarnate future tense of mankind. . . . While there is childhood there is hope. We must not let the children down."

Harry Emerson Fosdick.

• CALENDAR

July 3–7—National Education Association. Eighty-seventh annual meeting. St. Louis, Mo.

July 11–14—American Home Economics Association. Forty-first annual meeting. Boston, Mass.

July 16–22—International Conference of Social Work. General meeting. Paris, France.

July 24–28—Sixth International Congress of Pediatrics. Zurich, Switzerland.

Aug. 10–16—International Council of Religious Education—World Council of Christian Education Convention. Quadrennial convention. Toronto, Canada.

Aug. 31–Sept. 7—World Federation for Mental Health. Third annual meeting. Paris, France.

Sept. 4–9—American Psychological Association. Annual meeting. State College, Pa.

Sept. 5–7—National Council on Family Relations. Annual conference. Denver, Colo.

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WE CHANGE OUR SCHEDULE

With the present issue (June–July 1950) *The Child* begins a schedule of 10 issues a year instead of 12 as heretofore. The next issue will be for August–September.

TO WIPE OUT CONGENITAL SYPHILIS

Over the past 4 years the number of cases of early syphilis reported for the continental United States has decreased. The Venereal Disease Division of the Public Health Service states that this indicates a real decline in the incidence of syphilis.

Private physicians have had a large hand in bringing about this tremendous improvement in the health of the American people. But high credit must go, too, to the devoted band of venereal-disease control workers in public health services of communities, States, and the Federal Government.

Through their stimulation of research and professional training, their resourcefulness in case finding, their effective operation of rapid-treatment centers, and, above all, their skill in creating a more wholesome public attitude toward a disease that has been shrouded too long in disgrace, these workers have contributed immeasurably to the better health of our people. By reducing the ravages of syphilis, they have saved both to the public and to family budgets countless dollars that would have had to be spent for maintaining helpless and hopeless victims of its blight.

And now comes a challenge from Dr. Huse and Dr. Aufranc, in this issue of *The Child*, to all professional workers for children, and a plea to join forces with venereal-disease control workers in conquering congenital syphilis.

Over the same period when acquired syphilis has dropped by almost half, the number of reported cases of congenital syphilis have remained almost constant. And this despite the fact that for all these years the tool to prevent and to treat this most tragic of all forms of syphilis has been easy to get and easy to use.

With penicillin and the proper prenatal care, it is possible to prevent congenital syphilis in almost 100 percent of children.

With penicillin, when treatment starts early enough, excellent results can be obtained in the treatment of infants who have congenital syphilis.

These assurances come from competent authorities who have worked in this field for years.

Seldom have children's workers been presented with a more rewarding challenge to stamp out one of the most serious crippling conditions in children—serious not so much in the numbers of children affected but in the tremendous damage this disease does to their bodies and minds.

With effective teamwork, it should be possible not only to find every syphilitic pregnant woman, but to develop in her an attitude of confidence and cooperation that is basic to effective treatment, and to insure that she gets treatment.

Again, public health workers are leading the way in this health-bringing effort. At their meeting in Washington last October, the Association of State and Territorial Health Officers pledged themselves to intensify the work of maternal and child health and venereal-disease control units in State health departments "in order to find and treat pregnant women with syphilis," and, where this is not possible, to arrange for the treatment of children infected with congenital syphilis "as early as possible in life."

To this splendid leadership, all who work with children or with mothers can contribute greatly if they arm themselves with knowledge of the human cost of this controllable disease and dedicate themselves not only to find the mothers and children who need treatment but to help them get the treatment they need.

Katharine F. Lenroot

Chief, Children's Bureau.

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Arthur J. Altmeyer, Commissioner

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Katharine F. Lenroot, Chief

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